Written evidence submitted by the Department of Health and Social Care (MSE0062)

Evidence Submission for the Health and Social Care Committee Inquiry - *Safety of maternity services in England*

A joint memorandum from:

Department of Health and Social Care

NHS England and NHS Improvement

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Introduction

1. England is a safe place to give birth as evidenced by improving safety outcomes and women's reported experiences of care. Since 2010, there has been a 25% reduction in the stillbirth rate, a 26% reduction in the neonatal mortality rate for babies born over the 24-week gestational age of viability and a 14% reduction in the maternal mortality rate. At the same time, the latest Care Quality Commission (CQC) survey of women using maternity services shows a steady improvement in what they say about their care[1].

2. Work undertaken since 2015, under the auspices of the NHS England and NHS Improvement-led Maternity Transformation Programme (MTP), has improved partnership working between the Department of Health and Social Care (DHSC), its Arms-Length Bodies (ALBs), NHS maternity and neonatal providers, Royal Colleges and academics. We also have a significantly better understanding of the causal factors relating to mortality and morbidity in pregnant women and neonates which the system continuously seeks to address.

3. This joint memorandum from the Department of Health and Social Care and NHS England and NHS Improvement provides evidence on progress with delivery of maternity safety policy since November 2015, emerging challenges and the system's response.

Part 1 – policy, strategy, outcomes

Policy overview

4. The Government's commitment is to make the NHS the best place in the world to give birth through personalised, high-quality support. The National Maternity Safety Ambition is to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025, with an interim ambition of a 20% reduction in these rates by 2020. The original ambition was to halve these rates by 2030 but it was re-set on 28 November 2017 following the provision of additional funding and support[2]. An additional ambition to reduce the pre-term birth rate from 8% to 6% was also introduced in 2017.

5. The Maternity Safety Ambition was announced on 13 November 2015[3] against a backdrop of several inquiries into patient safety in the NHS culminating in *Learning, not blaming*[4] (the government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report, *Investigating Clinical Incidents in the NHS,* and the *Morecambe Bay Investigation*); the National Maternity Review[5]; and the first MBRRACE-UK[i] report on perinatal deaths, which found that UK stillbirth and neonatal mortality rates in 2013 were high when compared with some European comparator countries[6].

6. The Government set out the strategic direction and funding in 2016[7,8] and 2017[9] to support the NHS to implement a coherent system-wide approach to improving safety in maternity services.

[i] Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

DHSC's role is to set policy objectives, maintain oversight of the maternity system and to hold its ALBs to account. DHSC works closely with its ALBs and other partners to ensure a rapid system-wide response is taken to manage any risks that arise. A new DHSC Director General-led monthly meeting has been established with membership comprising NHS England and NHS Improvement (NHSE&I), the Care Quality Commission (CQC) and the Healthcare Safety Investigations Branch (HSIB) to monitor maternity provider performance based on available intelligence and data, and to identify services that could benefit from supporting interventions that promote safe care. This is in addition to existing NHS, CQC, HSIB and NHS Resolution (NHSR) functions.

7. NHS England established a Maternity Transformation Programme (MTP) in 2016 to implement *Better Births*, the report of the National Maternity Review[10]. It provides the architecture for delivery of most initiatives to improve safety in maternity care. The MTP works through 44 Local Maternity Systems, which have each been asked to co-produce (with local service users) and implement local plans to improve maternity care.

8. The two principal objectives of the MTP are to make care safer and more personal. A dedicated national work stream brings experts to identify and promote learning and best practice to improve the safety of care. But efforts to improve outcomes are embedded across the programme and supported by other key enablers, including the Maternity Workforce Transformation Strategy[11], improvements to data and intelligence collection and quality, and prevention activities, such as efforts to reduce maternal smoking. A comprehensive review of progress with the MTP was published in March 2020 (attached as Annex A).[12] The NHSR CNST[ii] Maternity Incentive Scheme provides an additional incentive for implementation of safety initiatives.

Maternity Safety Strategy

9. The Maternity Safety Strategy comprises evidence-based initiatives to support the maternity system to strengthen leadership, implement best clinical practice and develop cultures of continuous learning for improvement as essential components for achieving the National Maternity Safety Ambition.

10. Most of the safety initiatives announced in 2016 and 2017 maternity safety strategy documents are in progress. They have been supplemented by improvements to care identified through the on-going development of the MTP and included in the NHS Long-Term Plan. Further details are provided in Annex B.

11. The strategy is structured on evidence-based drivers for delivering personalised and safe maternity care, primarily:

a. **Leadership** – promoting safe person-centred care, openness, respect and support in multi-professional and multi-disciplinary teams;

[ii] Clinical Negligence Scheme for Trusts

b. **Delivering best practice** – through research, staff training and standardisation of evidence-based care; and

c. **Learning for improvement** – collecting and analysing input, output and outcome data for insights into potential improvements, commissioning research, reviewing/investigating cases of unexpected morbidity/mortality at local and national levels (including learning from audit programmes, case reviews, investigations and inquiries), and implementing structured quality improvement processes.

Leadership

12. 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: Dr Matthew Jolly, National Clinical Director for Maternity and Women's Health, and Professor Jacqueline Dunkley-Bent OBE, the Chief Midwifery Officer for England. Sarah-Jane Marsh, Chief Executive of Birmingham Women's and Children's NHS Foundation Trust, leads the MTP programme board.

13. The national Champions lead by working across professional groups and system boundaries to maintain the emphasis on safe maternity care for women and newborns. They promote learning and innovation and share best practice across the system through guidance[13], bi-monthly WebEx meetings and newsletters. Within Trusts, frontline Champions (one obstetrician, one midwife and one neonatologist) work closely with a Trust Board Champion to promote unfettered 'floor-to-board' communication.

14. Leadership for transformation is embedded through the 44 Local Maternity Systems, which bring together service users, providers and commissioners to design and implement improvements to maternity services. Service users are powerful advocates for safer maternity care, and the establishment of local Maternity Voices Partnerships has helped to ensure there is a channel for their input across England. Regional boards established across the seven NHS England and NHS Improvement regions are supported by seven new regional chief midwives.

Delivering best practice

15. The evidence on safe maternity care is substantial and growing through National Institute for Health Research (NIHR)-funded research, audits, and reviews/investigations of unexpected mortality/morbidity outcomes (e.g. Perinatal Mortality Reviews, HSIB investigations and the NHSR Early Notification Scheme), and nationally commissioned inquiries such as the Morecambe Bay Investigation.

16. Every NHS maternity service is actively implementing elements of the Saving Babies Lives Care Bundle (SBLCBv2[14]), which set out specific care pathways to reduce smoking in pregnancy; improve risk assessment, prevention and surveillance of pregnancies at risk of fetal growth

restriction; raise women's awareness of reduced fetal movement; improve fetal monitoring during labour; and reduce preterm birth.

17. Evidence shows that better outcomes and experiences, as well as reduced health inequalities, are possible when people have the opportunity to actively shape their care. Personalisation, based on a robust and continued assessment of an individual's circumstances and choices and, a relationship of trust with clinicians, is a prerequisite for the safest care. A Cochrane review found that women who received midwife-led continuity of care were 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks, and 24% less likely to experience pre-term birth[15]. NHS maternity services are working to enable most women to receive continuity of carer during pregnancy, birth and postnatally.

Learning for Improvement

18. Significant improvements have been made in reviewing/investigating and learning in unexpected morbidity/mortality cases. The Perinatal Mortality Review Tool (PMRT) is used by every maternity service and the first national review report was published in October 2019[16]. HSIB completed roll out of its maternity investigation programme to all regions in England in April 2019 and published its first national thematic learning report in March 2020[17].

19. Beginning in 2018, the Maternal and Neonatal Health Safety Collaborative (now the Maternity and Neonatal Safety Improvement Programme) has helped providers to translate learning into improvement by supporting them to better understand and overcome local barriers to improvement and culture change.

Continuous Professional Development (CPD) Training

20. In 2016, Health Education England (HEE) distributed over £8.1 million to 136 NHS Trusts across England to deliver maternity safety CPD training[18]. This supported the delivery of over 30,000 training places across multi-professional/multi-disciplinary teams.

21. A new core curriculum for professionals working in maternity and neonatal services is being developed by the MTP in partnership with professional organisations, clinicians and service users to address variations in safety training and competency assurance across England and to enable the workforce to bring a consistent set of updated safety skills as they move between services and Trusts.

Workforce

22. In March 2018, DHSC committed to increasing the number of available midwifery training places in England by more than 3,650 over a four-year period from 2019. The increase in available places started in the 2019 academic year, with an additional 650 training places, with increases of 1,000 planned in subsequent years.

23. In February 2019, HEE launched the Maternity Support Worker (MSW) Competency, Education and Career Development Framework with £1m of funding to boost delivery and implementation across England to standardise this role. MSWs make a vital contribution in delivering safe and personalised care for women and their babies.

Progress towards achieving the Maternity Safety Ambition

24. Overall, the outcome data shows that maternity and neonatal services are making clear progress across the National Maternity Safety Ambition elements. Two factors provide important context when interpreting progress with meeting the ambition:

a. There is a time lag to realise the impact of interventions; and

b. There are two to three-year time lags in publishing national mortality and brain injury data and the latest published rates do not reflect efforts in the months/years since that period.

25. The data shows that maternity safety outcomes have improved since 2015 at a time of increasing complexity and risk factors in the maternal population (e.g. increasing maternal age, obesity and pre-existing co-morbidities). Women are also reporting improvements in their experiences of maternity care[19]. Further details of progress towards achieving the Maternity Safety Ambition are provided in Annex B.

Stillbirth

26. Since 2010, the stillbirth rate in England has decreased by 25% and is ahead of the target to meet the 2020 ambition. In October 2019, MBRRACE-UK reported that there has been a substantial reduction in stillbirths recorded as having an intrapartum cause from 189 (5.8%) stillbirths in 2014 to 51 (1.8%) stillbirths in 2017 and proposed that this progress can at least partially, be attributed to the national initiatives focused on the reduction of stillbirths[20]. It is anticipated that the pace of reducing the overall rate of stillbirths will increase as SBLCBv2 interventions continue to embed (See Annex C, Chart 1).

Neonatal mortality

27. According to the Office for National Statistics (ONS), neonatal mortality rates decreased until 2014 before rising again. This increase relates solely to additional deaths reported in the first day of life in babies born showing signs of life at or below the extremes of viability[21]. The increasing number of 'live births' below 23 weeks' gestation may relate to changes in neonatal practice reflecting recent guidance from British Association of Perinatal Medicine, and coroners' directives that any baby born with a detectable heartbeat should be considered a live birth, whatever the gestation. The overall effect is that some cases recorded as miscarriages in 2010 are now recorded as neonatal deaths. The MBRRACE-UK Perinatal Mortality Surveillance Report 2017[22] highlighted this issue reporting 23% of all neonatal deaths occurring in babies born before 24 weeks. It also shows

that the UK neonatal mortality rate for babies born at 24 weeks gestational age or later decreased around 10% from 1.84 to 1.67 deaths per 1,000 live births over the five years from 2013 to 2017.

28. The MBRRACE-UK 2017 report also shows that congenital anomalies account for over a third of neonatal deaths. There has been an increasing trend in the proportion of neonatal deaths recorded as congenital anomalies (from 27.9% in 2014 to 36.1% in 2017) although numbers of neonatal deaths in this category have remained fairly constant over the past three years. As the overall neonatal death rate continues to fall the proportion of deaths due to congenital anomaly will have an increasingly important effect.

29. We are currently working with the ONS on a national statistic to measure progress towards the neonatal mortality national ambition that better takes these issues into account (See Annex C, Chart 4).

Pre-term birth

30. 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 SBLCBv2 has been revised to include a new initiative to address this. In addition, the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), in collaboration with the British Association of Perinatal Medicine, is promoting best practice for optimising outcomes for very preterm babies who are most at risk of brain injury and neonatal death.

Brain injuries occurring during or soon after birth

31. The overall rate of brain injuries occurring during or soon after birth is variable but shows no trend downwards. According to a definition developed in 2017[23,24], the brain injury rate has fallen to 5.1 per 1,000 births in 2017, since rising from 4.9 to 5.4 per 1,000 births between 2012 and 2014. The rate of term infants with hypoxic ischaemic encephalopathy has fallen by 11.8% between 2014 and 2017. We are seeking ways to obtain more timely data on brain injuries, especially those resulting from avoidable harm, understanding that some brain injuries do not manifest for two or more years.

Maternal mortality

32. Maternal deaths are very rare, with the latest figures showing just 9.2 per 100,000 maternities. Small numbers mean the data has to be combined into a rolling triennial rate, which is only available on a UK-wide basis (not England only). Even when three years of data are combined, changes from one three year period to the next must be interpreted with caution as they may be due to natural statistical variation. Greater reliance should therefore be placed on the longer term trajectory. This shows a 14% reduction in the triennial maternal mortality rate up to 2015-17, which is in line with the trajectory required to meet the 2020 ambition.

Part 2 – New challenges, early warning and litigation

Current and emerging challenges

33. In March 2020, the CQC highlighted that the current NHS maternity service ratings show improvement since 2017 (including a considerable reduction in the number of services rated 'inadequate' or 'needs improvement' for safety), and the reduction in mortality rates has been quicker over the last few years[25]. However, the CQC also found that there is still too much variation in the safety and quality of maternity services and improvements focused on developing safety culture in trusts rated as 'needs improvement' or 'inadequate' are required.

34. Other issues include:

a. The ethnic and socio-economic disparities in maternal and perinatal mortality outcomes and experience, including women from Black, Asian and other minority ethnicities. The Chief Midwifery Officer, with support from DHSC and other Government Ministers, is leading work to address this with maternity leaders and service users. Local understanding of underpinning culture, causes and solutions is required to improve outcomes and experiences of care for all service users. Maternity Voices Partnerships are improving involvement of local groups and individuals in service design and delivery. The new NHS Race and Health Observatory will also be working on this issue.

b. The national rate of brain injuries occurring during or soon after birth, which has remained relatively steady according to a definition developed in 2017. We are focussing particularly on reducing harm leading to serious brain injuries that can have long-lasting and devastating impacts on babies and their families.

c. COVID-19 has had an impact on maternity services, which have responded well in caring for both infected and uninfected women in acute settings and in the community and doing all they can to keep mothers and babies safe. Some initiatives have been suspended to take as much burden off Trusts as possible during the pandemic, so that they can focus on the safe delivery of front line care. There remain uncertainties about the impact of COVID-19 on perinatal and maternal mortality. Research from MBRRACE-UK shows that overall mortality of pregnant women from complications from COVID-19 appears to be low,[26] but other issues, such as antenatal care during the pandemic, may have an impact.

35. As the health system moves into COVID-19 recovery phase, priorities remain focussed on improving maternity safety, learning from incidences of harm and supporting all pregnant women to have safe, personalised care.

The NHS Long-Term Plan and Patient Safety Strategy

36. The NHS Long-Term Plan (2019)[27] sets out how the maternity system will continue to accelerate action to achieve the National Maternity Safety Ambition. Key initiatives include

implementing an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies; investment in neonatal critical care services and networked maternal medicine; and offering all pregnant women with type 1 diabetes continuous glucose monitoring, helping to improve neonatal outcomes.

37. Maternity safety initiatives will be delivered within the NHS Patient Safety framework[28] building on the foundations of a patient safety culture and a patient safety system and three strategic aims:

a. **Insight** - improving understanding of safety by drawing intelligence from multiple sources of patient safety information;

b. **Involvement** - equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system; and

c. **Improvement** - designing and supporting programmes that deliver effective and sustainable change in the most important areas supported by the Maternity and Neonatal Safety Improvement Programme.

Early warning, escalation, and improvement

38. Independent inquiries into the specific services where there have been serious failings such as the Shrewsbury and Telford Hospital NHS Trust and the East Kent Hospitals University NHS Foundation Trust have been established to ensure families get the answers they deserve; to ensure Trusts learn as much as they can from tragic cases of harm; and to give maternity service users the reassurance that they will receive safe, high-quality care at all times.

39. These and other reviews/investigations emphasise the need for transparent maternity leadership, governance at every level of the system and better data and intelligence to identify services that could benefit from early support to prevent them becoming unsafe. National bodies (including NHSE&I, CQC, HSIB, and NHSR) have established processes to identify and escalate concerns about the quality of care in individual trusts.

40. While some processes are unique to the maternity setting, NHS providers are also subject to the routine quality surveillance mechanisms which apply to all services: locally through board level oversight (supported by board Maternity Safety champions), at system level (in maternity through Local Maternity System challenge/support); regionally and nationally through the quality surveillance group infrastructure, and Joint Strategic Oversight Groups. At each level, a combination of data and soft intelligence is used to identify potential and actual quality problems and to take appropriate action.

41. NHSE&I is working with other national bodies to finalise a new dedicated maternity data/intelligence module to operate through the system quality surveillance and governance structures to enable identification and escalation of concerns.

42. There is also a system of strengthened professional leadership in place through the Chief Midwifery Officer and her team of Deputy and Regional Chief Midwives that supports sharing intelligence and about the quality of care, early escalation and support.

43. NHSE&I's current highest level of maternity-specific response involves placing trusts on the Maternity Safety Support Programme (MSSP). This involves senior clinical leaders providing hands on support to provider trusts, through visits, mentoring, and leadership development. Its original inclusion criteria were:

a. maternity services which have an overall rating of inadequate by the CQC;

b. maternity services which have an overall rating of requires improvement with an inadequate rating for either the safety or well-led domains by the CQC; and

c. maternity services issued with a CQC warning notice.

44. Following the success of the MSSP in supporting eleven maternity services over the last two years, the decision was taken to broaden the entry criteria for trusts. The aim of the programme as it enters its third year is to enable it to work proactively with identified trusts to advise and support them to improve their CQC rating or address any other areas of concerns raised by other stakeholders. This proactive approach will seek to support organisations potentially showing early signs of deterioration in maternity services quality and safety to enable a targeted and bespoke improvement offer by an allocated Maternity Improvement advisor.

Clinical Negligence and Litigation

45. Each maternity incident is a tragedy, and incidents during birth can have long-lasting and devastating impact on a patient and their families. Our focus as set out above is on improving maternity safety and learning from harm to reduce the risk of similar incidents happening again. It is also very important to be open with affected patients/families, giving apologies as required by the Duty of Candour - clinicians can be confident that an apology is not an admission of liability - and involving families in investigations should they wish. NHSR endeavours to ensure NHS staff are aware that the potential for litigation is not a barrier to saying sorry[29].

46. Being involved in a serious incident can also have a very serious impact on the clinical staff involved. We must take very seriously the negative experiences of staff who have been involved in incidents and the effects that often multiple and drawn-out processes can have on them as professionals and as people.

47. We are seeking to embed a just culture in the NHS so that providers move from blame or punitive actions to learning from mistakes and continuous improvement, and this will take time and effort. The NHS Patient Safety Strategy will monitor and support this development. For example, through their inspections, CQC will identify 'closed' cultures, picking up where staff feel afraid to

raise issues. NHSR's *Being Fair* publication[30] sets out approaches to treat staff and patients fairly when things go wrong.

Learning from claims

48. Patients have a right to compensation if they are harmed by clinical negligence. Some patients who have brought claims say that their primary motivation for doing so was to prevent the same thing happening to someone else rather than to seek compensation[31]. Litigation can uncover poor practice and claims can give rise to new learning; NHSR's work to create insight from claims, such as their *Five years of cerebral palsy claims'* report[32], can enable front-line clinicians to take steps to prevent the same kinds of harm from recurring.

49. However, because most claims take many months or years to be brought then resolved, learning from a specific event may not be available in a timely way, meaning staff may have moved on or procedures changed long before the claim findings become available. For that reason, safety infrastructure such as incident reporting and investigations is in place to ensure that local learning, and where appropriate action against poorly performing clinicians, can happen much more speedily after the event has occurred.

Conclusion

50. This memorandum has set out work and progress since 2015 on achieving the National Maternity Safety Ambition by focussing on leadership, implementing best practice and learning for improvement. It has also set out how the maternity system will build on a substantial body of new evidence and learning gained over the past five years. Particular focus will be on:

a. Improving outcomes for women and babies from Black, Asian other minority ethnicities and deprived backgrounds by delivering enhanced and targeted continuity of carer; helping to reduce pre-term births, hospital admissions, and the need for intervention during labour.

b. Reducing harm leading to serious brain injuries at birth that can have severe and devastating impacts on families and potentially significant cost implications to the NHS. We have described a core competency-based approach to improving individual staff competencies, team working and multi-professional training. It is also important that learning happens at the point when something goes wrong and effective learning can only happen where organisational culture is open, and all staff are fully equipped and supported to disclose and reflect on mistakes they or their colleagues might have made. There is still more work to be done to understand the contributors to feelings of blame, how barriers to learning can persist and actions that may tackle these issues.

c. Strengthening governance, leadership and risk management. We have described how leadership across the maternity system is being strengthened, most recently by

the establishment of a team of Regional Chief Midwives led by the Chief Midwifery Officer; how risk management and governance is being strengthened; and how the MSSP will proactively support Trusts to improve their CQC ratings for maternity.

Annex A – Better Births Four Years On: A review of progress

https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf

Annex B: Maternity Safety Programme Initiatives and their expected impact time frame

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

Best Practice - Neonatal Critical Care Review Implementation	2017	2020-21	2021-22	2022-24	✓	✓		✓	
Best Practice - NHSR CNST Maternity Incentive Scheme	2017	2018-19	2019-20	2020-22	✓	✓	✓	✓	✓
Learning for Improvement - HSIB Maternity Investigations	2017	2018-19	2019-20	2020-22	✓	✓	✓	✓	✓
Learning for Improvement - Each Baby Counts Learn & Support	2017	2018-19	2020-21	2022-24	✓	✓		✓	✓

Annex C: Progress towards achieving the Maternity Safety Strategy

Chart 1: Stillbirth rate trend for all births in England

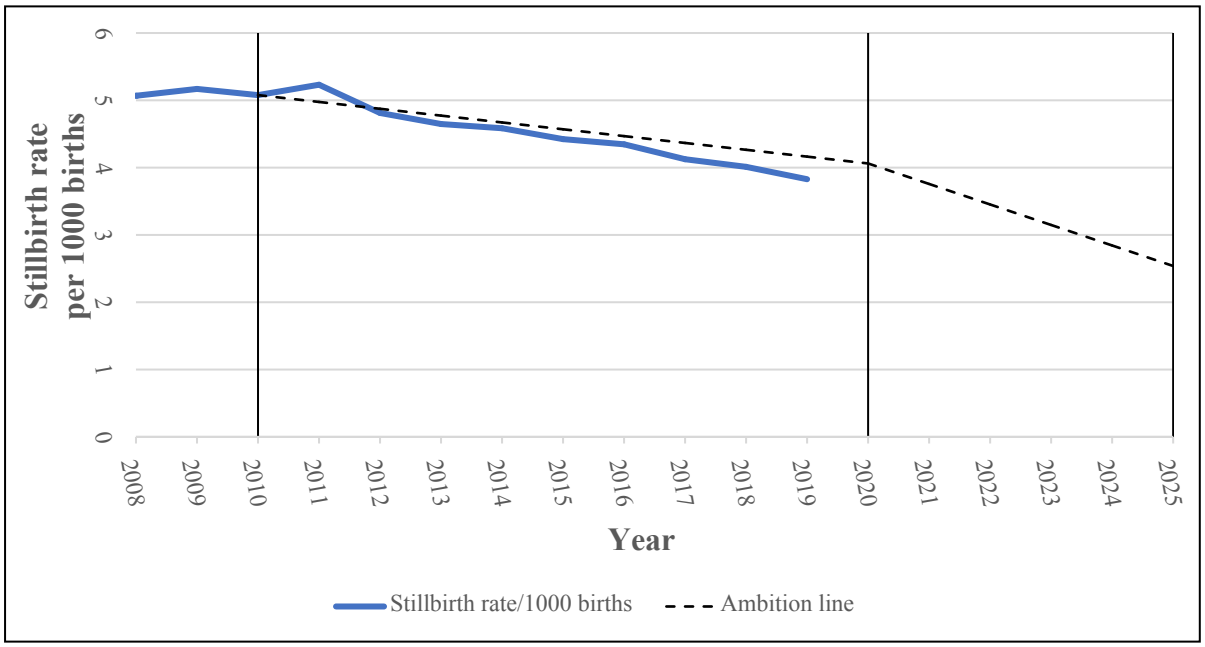


Chart 2: Neonatal mortality rate trend in England

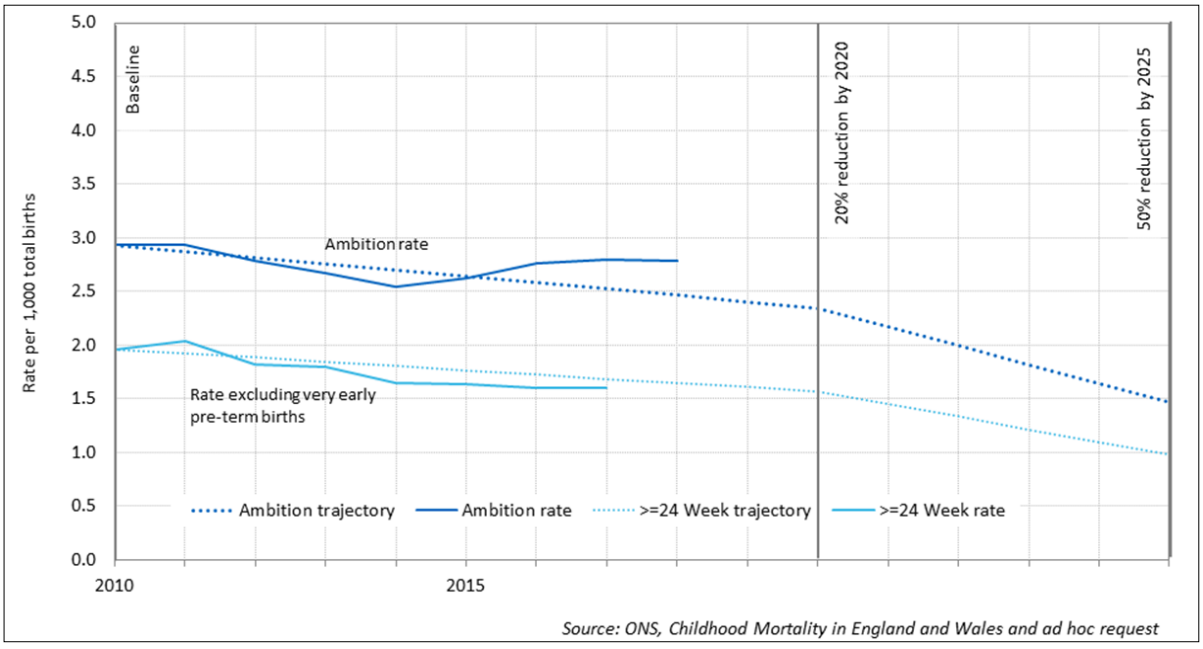


Chart 3: Live births and neonatal deaths in babies born before 24 weeks gestation in England

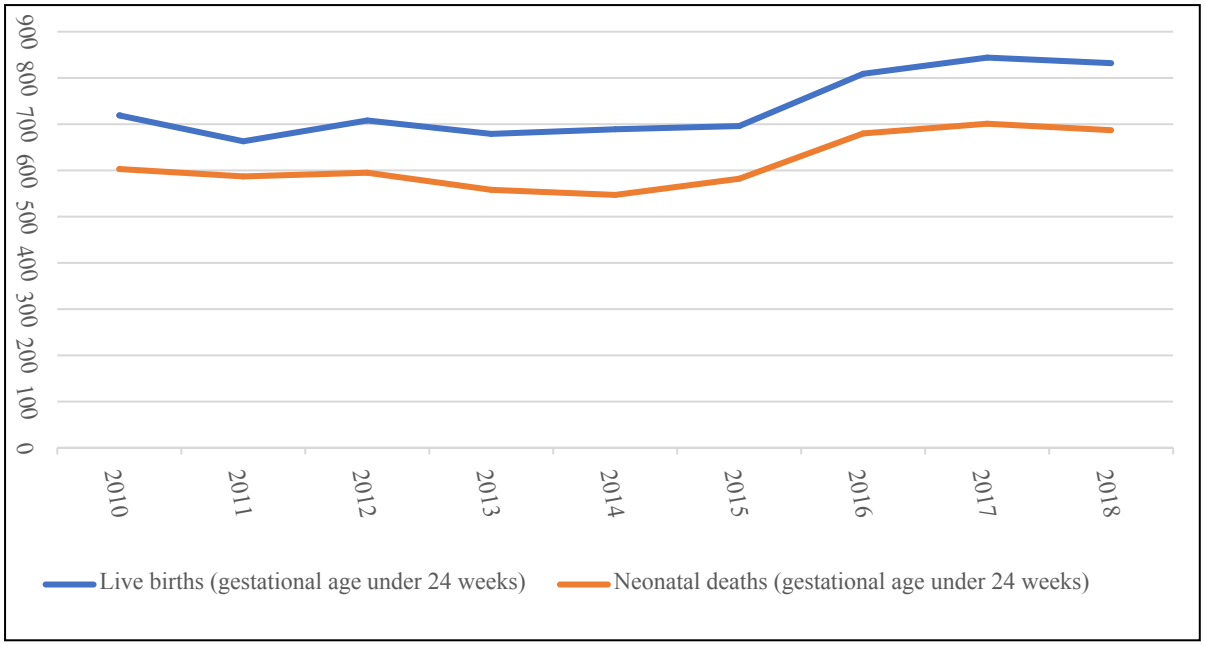
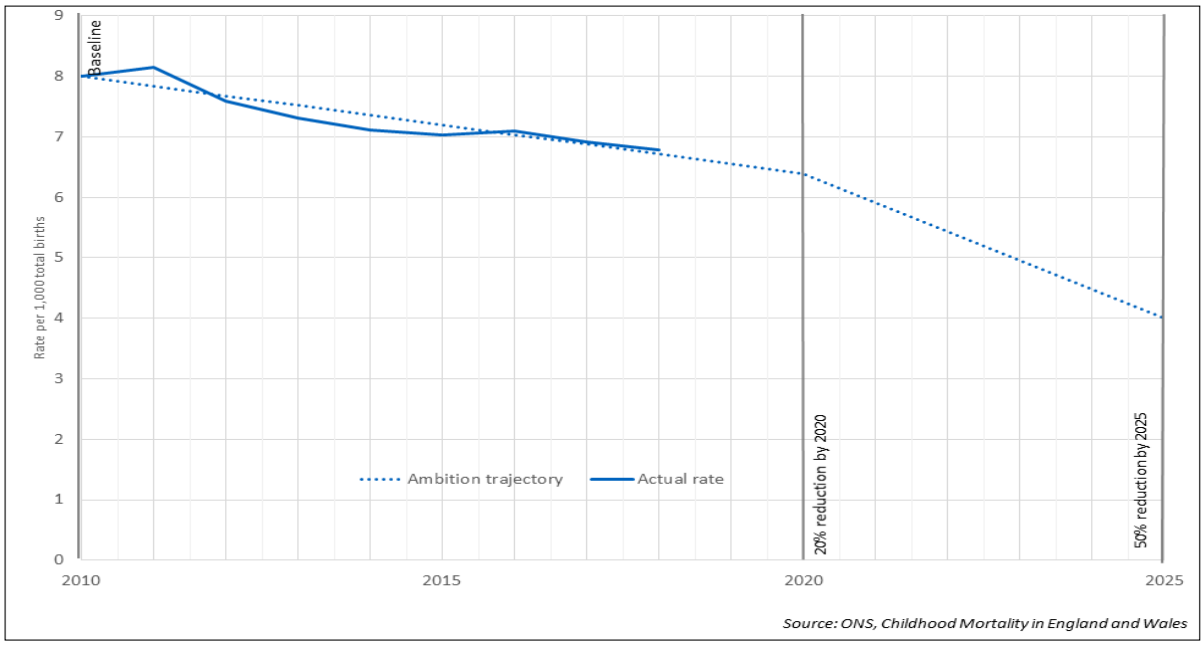


Chart 4: Composite stillbirth and Neonatal death rate trend in England



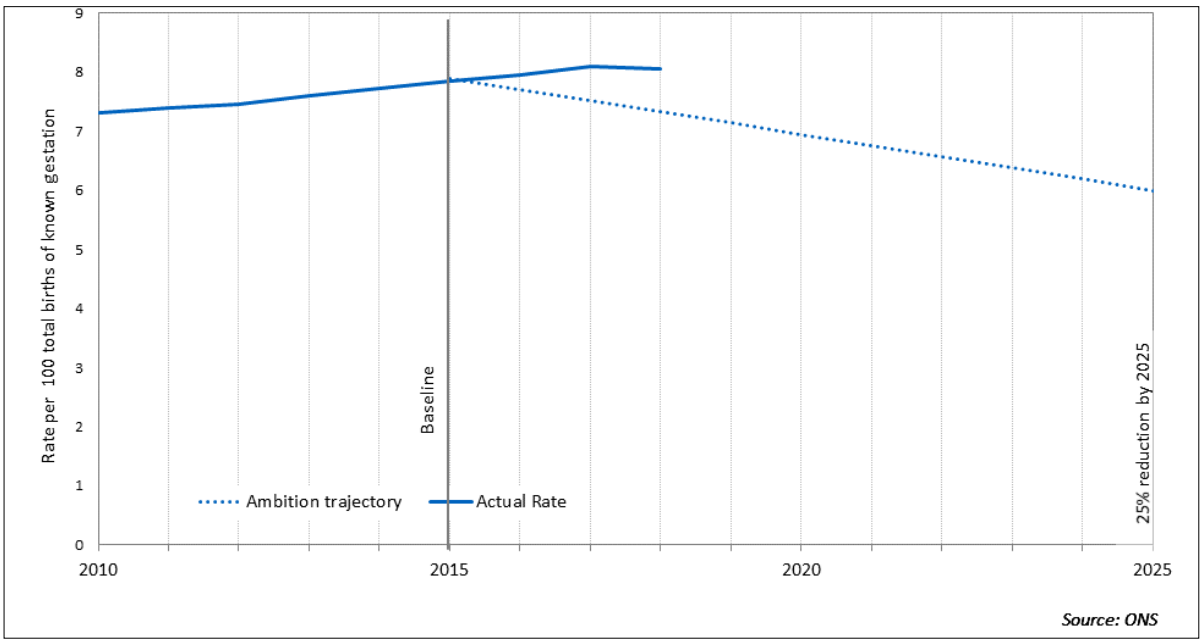


Chart 5: Pre-term birth rate

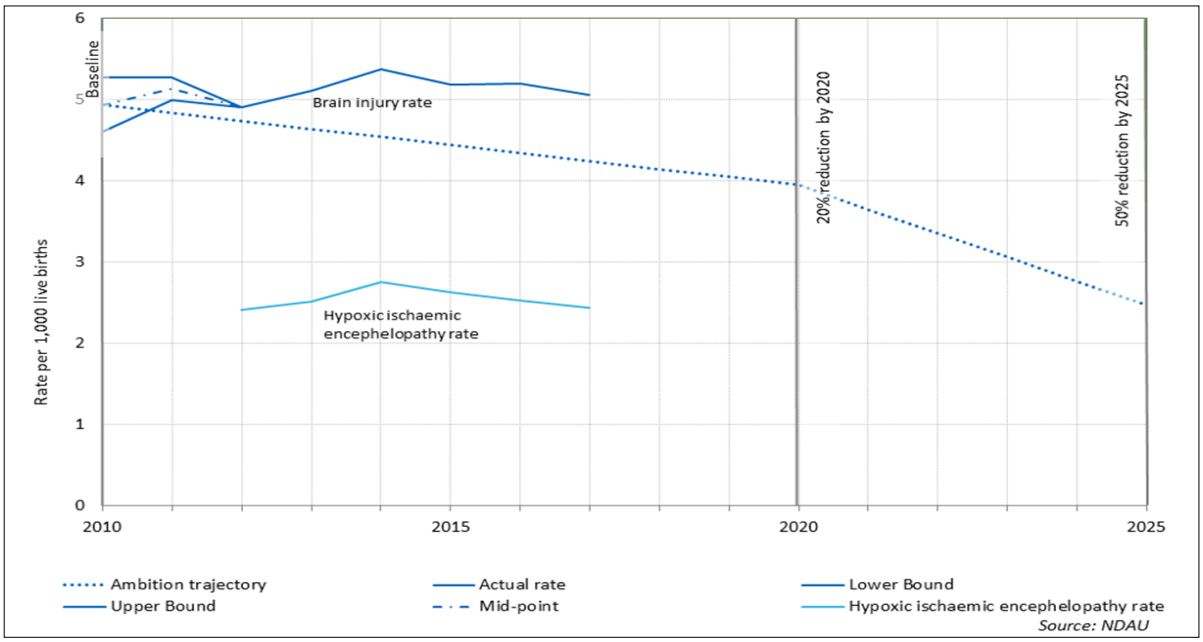


Chart 6: Overall brain injuries occurring during or soon after birth

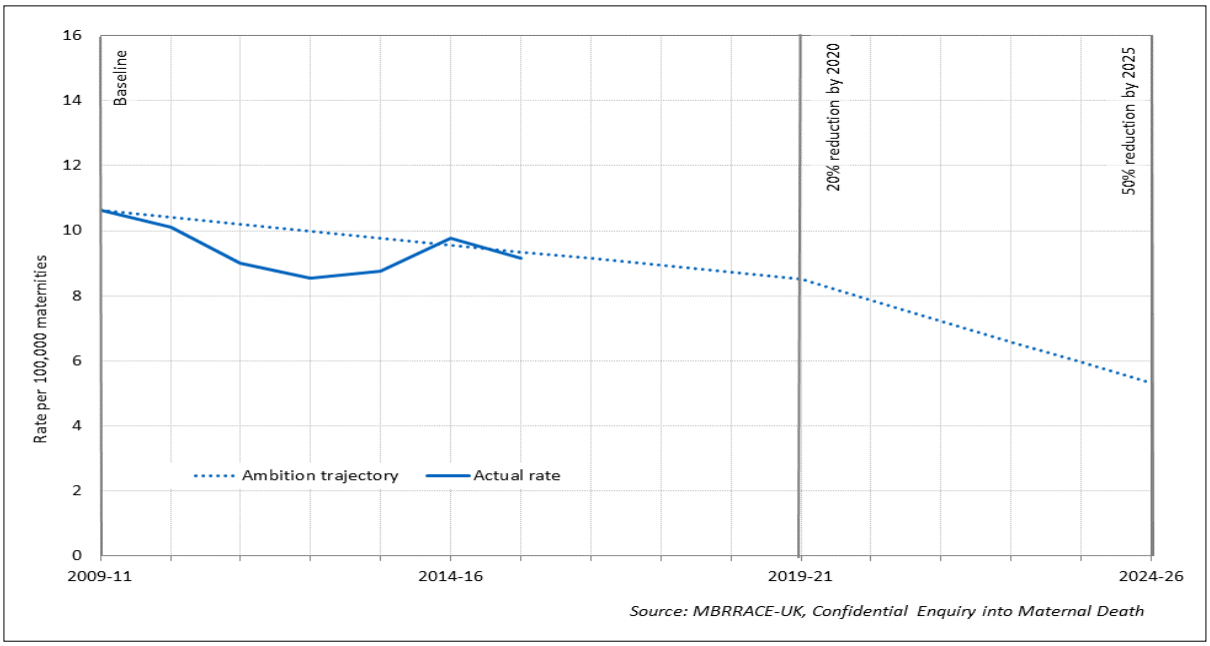


Chart 7: Maternal mortality rate trends since 2010

Annex D: References

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