National initiatives for maternity and neonatal safety in England

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PATIENT SAFETY
Working together

The publication of the Kirkup report[1] in early 2015, following the Morecambe Bay investigation, propelled maternity safety into the public spotlight. As maternity teams considered recommendations from the report, a review of maternity services in England, led by Baroness Cumberlege, began. The review findings, supported by 27 recommendations, resulted in the publication of *Better Births*.[2] Findings from MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) highlighted opportunities to improve care in relation to maternal and infant mortality and morbidity, providing key recommendations to address identified needs.[3] The increasing focus on maternity safety in England was enhanced further in November 2015 when a new national maternity ambition was announced: to reduce the rate of stillbirths, neonatal and maternal deaths, and brain injuries occurring during or soon after birth by 20% by 2020, and 50% by 2030.[4]

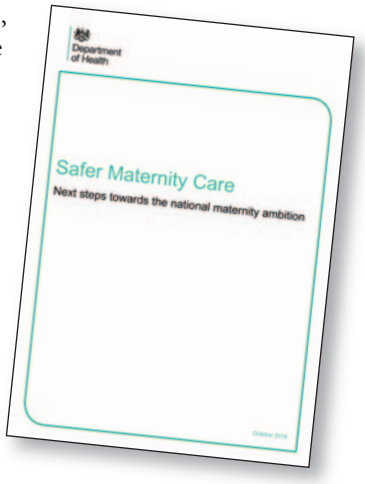
In October 2016, Secretary of State for Health Jeremy Hunt announced the Safer Maternity Care – Next Steps Towards The National Maternity Ambition action plan.[5] Aimed at building on existing initiatives to improve maternity safety in England, the plan asks for support from NHS staff and leaders at every level; encouraging teams to focus on improvements that will make a difference locally. Specific emphasis has been placed on ensuring that teams and cultures are supportive and open to learning and positive change.

Collectively, this activity has resulted in unprecedented investment and a spotlight on improving safety across perinatal services. This article describes the five core themes around which the plan has been designed, outlines the key elements of the plan and highlights opportunities where neonatal and maternity teams might work cohesively to improve safety across perinatal services.

Five core themes

The maternity safety action plan is focused around five key themes:

Leadership: with the aim of creating strong leadership for maternity systems at every level, maternity safety champions Jacqueline Dunkley-Bent and Matthew Jolly have been appointed at national level. At regional level maternity networks have been tasked with designating a Maternity Safety Champion to act as improvement advisor, coach and conduit for sharing learning. This role will include responsibility for developing and fostering relationships with neonatal Operational Delivery Networks (ODNs). Within each trust a board level maternity champion will ensure communication from the front line to the board, optimising flow of communication and prioritising maternity safety at board level. In addition, trusts are asked to designate one obstetrician and one midwife to take on responsibility for championing maternity safety locally. Neonatal teams are well placed to harness these new opportunities to work with their maternity colleagues to collectively improve perinatal care and safety.



The second theme, **learning and sharing best practice**, is achievable through implementation of the Saving Babies' Lives care bundle, ATAIN and other evidence-based programmes. In addition, networks and local teams can demonstrate learning from investigations by ensuring that changes made as a result of lessons learned have been effective. Joint reviews of clinical incidents by maternity and neonatal teams offer dual insights and optimise learning across the wider team.

A third theme, **focusing on teams**, requires prioritisation and investment in the capability and skills of the workforce by promoting effective multi-professional team working. Significant investment in team training through access to a multi-million pound training fund has been made available to both neonatal and maternity teams.

Using data to demonstrate improvements requires all trusts to report to the Maternity Services Dataset, MBRRACE-UK, the Each Baby Counts programme, the National Neonatal Dataset and the new National Maternity and Perinatal Audit. Once launched, maternity and neonatal teams are expected to use the Standardised Perinatal Mortality Review Tool to review and share learning from every stillbirth and neonatal death.

The fifth theme relates to **promoting innovation** by harnessing creativity and space to accelerate improvement. A £250,000 maternity safety innovation fund was established to support and promote the adoption of innovation and the spread of best practice across NHS maternity services.

Elements of the maternity and neonatal safety action plan

Multidisciplinary training fund

Every trust in England will have received a proportion of an £8 million fund for multidisciplinary team training. Up to £80,000 of funding per trust has been allocated.

Innovation fund

Over 100 applications were received as part of a £250,000 innovation fund. The aim of the fund is to promote creativity and innovation for improvement. We hope to share examples of safety improvements in future articles through *Infant* journal.

Our Chance campaign[6]

A public-facing communications campaign developed in partnership with two key charities, Sands and Best Beginnings. The 12-week campaign focuses on a different theme each week with relevant films, social media and consumer media.

National QI programme

The national maternal and neonatal safety collaborative is a new initiative launching in Spring 2017 to support improvements in the quality and safety of NHS maternity and neonatal units. All NHS trusts in England that provide maternity services are asked to collaborate through the three-year programme, which will support trusts to make measurable improvements in safety outcomes for women, their babies and families by exchanging ideas and best practice among other units regionally and across the country. The programme will provide trusts with access to quality improvement training and expertise, and enable them to work collaboratively to improve clinical practices, reduce unwarranted variation and contribute to achieving the national ambition.

Saving Babies' Lives care bundle[7]

The care bundle is designed to tackle stillbirth and early neonatal death. It brings together four elements of care, recognised by experts as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour.

ATAIN[8]

An acronym for Avoiding Term Admissions Into Neonatal units, the ATAIN programme has worked with experts to understand and address rising admission rates of full term babies to neonatal units. The programme of work will offer a package of publications and resources to maternity and neonatal teams to support them to provide safer care and avoid harm leading to unnecessary separation of mother and baby.

Rapid Resolution and Redress (RRR)

The RRR proposal will provide support and an alternative to litigation for families who experience severe avoidable birth injury (cerebral palsy/brain damage). The scheme will aim to tackle three issues:

1. Reducing the number of severe avoidable birth injuries through improved learning
2. Improving the experience of families and clinicians when things go wrong
3. Making more effective use of NHS resources.

A public consultation will be launched shortly.

Monitoring progress[9]

The Clinical Commissioning Group's Improvement and Assessment Framework: Maternity will measure progress in local areas and identify which areas have most scope for improvement. The Department of Health plans to publish the first annual report on the national ambition in March 2017.

The national ambition spans a 15-year period. Throughout this period of time plans will be reviewed and updated to ensure current and emerging needs are met. The elements outlined in this article therefore reflect activity over the next 12-18 months. It is intended that this overview of activity provides readers with an awareness of opportunities open to the perinatal community in order to harness existing investment and political attention to enhance care and safety for new and expectant mothers, newborns and families.

Acknowledgement

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References

1. **Kirkup B.** *The Report of the Morecambe Bay Investigation.* [2015] Online. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [accessed 20 Dec 2016].
2. **National Maternity Review.** *Better Births: Improving Outcomes of Maternity Services in England.* [2016] Online. Available from: www.england.nhs.uk/2016/02/maternity-review-2 [accessed 20 Dec 2016].
3. **MBRRACE-UK.** *Reports.* Available from: www.npeu.ox.ac.uk/mbrrace-uk/reports [accessed 20 Dec 2016].
4. **Department of Health.** *New Ambition to Halve Rate of Stillbirths and Infant Deaths.* [2015] Online. Available from: www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths [accessed 20 Dec 2016].
5. **Department of Health.** *Safer Maternity Care: Next Steps Towards the National Maternity Ambition.* [2016] Online. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf [accessed 20 Dec 2016].
6. **Our Chance Campaign.** Available at: http://ourchance.org.uk [accessed 20 Dec 2016].
7. **NHS England.** *Saving Babies' Lives: A Care Bundle for Reducing Stillbirth.* [2016] Online. Available from: www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf [accessed 20 Dec 2016].
8. **NHS Improvement.** *Reducing Term Admissions to Neonatal Units.* [2016] Online. Available from: https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units [accessed 20 Dec 2016].
9. **Clinical Commissioning Group.** *Improvement and Assessment Framework: Maternity.* [2016] Online. Available from: www.england.nhs.uk/ourwork/futurenhs/mat-transformation/maternity-iaf [accessed 20 Dec 2016].