Maternity and neonatal safety: new initiatives for improvements in England

British Association of Perinatal Medicine
infant
PATIENT SAFETY
Working together

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Two years ago the Department of Health and Social Care (DHSC) in England set a challenging ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030, with an expectation of a 20% reduction by 2020.[1] In November 2017, in his third autumn announcement, Secretary of State for Health and Social Care Jeremy Hunt outlined his refreshed strategy for maternity care in England, which includes a number of new measures to drive improvements in maternity and neonatal care further and faster.[2] This article provides a brief overview of the new announcements that collectively offer ongoing investment and focus on improving safety across both maternity and neonatal services, with a number of initiatives relating specifically to support for improvements in neonatal outcomes.

More support for better, safer care

Building on the requirements for maternity safety champions at every level of the system outlined in *Safer Maternity Care, Next Steps Towards the National Maternity Ambition*,[3] NHS Improvement is developing a central platform within the online NHS Improvement Hub to support the role of maternity safety champions. The hub will be live by late January and will play a key role in enabling and fostering a cohesive community of leaders and experts to help spread learning and best practice across the system.

To support trusts and commissioners to meet the aim of better and safer care and to assist with implementation of the *Saving Babies' Lives Care Bundle*,[4] new funding has been set aside to train midwives and upskill practitioners, including maternity support workers. This is particularly focused on the smoking cessation element of the care bundle and is aimed at developing their knowledge, skills and confidence to give very brief advice[5] to women during antenatal appointments as well as to deliver evidence-based smoking cessation interventions.

A three-year funded programme to train 12 consultant physicians as 'obstetric physicians' will be set up. The programme aims to establish a network of maternal medicine specialists across England. Together with an obstetrician trained as a 'sub-specialist in maternal medicine' the obstetric physician will provide expert care for pregnant women with complex medical problems. In addition they will provide region-wide leadership and expertise across the network to ensure early recognition of problems and access to best practice care.

A new e-Learning programme to address findings from Atain,[6] the work programme led by NHS Improvement to reduce avoidable admissions to neonatal units, has been launched. The e-Learning programme aims to support healthcare professionals to improve outcomes for babies, mothers and families through the delivery of safer care with a focus on four clinical areas:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxic-ischaemia).

An additional module also raises awareness of the psychological importance of keeping mother and baby together.

Measures to improve the quality of reviews and investigations

The development of a new Perinatal Mortality Review Tool,[7] led by MBRRACE-UK, will encourage systematic, multidisciplinary, high quality reviews of the care and circumstances leading to each stillbirth and neonatal death. It will support a structured process of review, learning, reporting and actions to improve future care; and promote active communication with parents regarding the need for the review and how parents can contribute to the process. A meaningful 'plain English' report for parents with an explanation of why their baby died is included in the scope of this work.

Improving the quality of investigations in order to learn from serious incidents is of system-wide importance and highlighted as a priority to be addressed by a

The DHSC's recent publications on maternity and neonatal care in England.

number of recent publications.[8-10] As part of its commitment to improving the standards and quality of investigations and learning from serious incidents, the DHSC has allocated new funding to enable the Healthcare Safety Investigation Branch (HSIB)[11] to develop investigation standards and conduct independent investigations into all cases that meet the Each Baby Counts[12] programme definition and all maternal deaths from direct or indirect causes related to pregnancy.

NHS England, working with NHS Improvement, the DHSC and HSIB will publish information and guidance on the standards for maternity investigations to deliver the Kirkup report and *Better Births* recommendations.[13,14] This guidance will be available by the second quarter of 2018.

Currently coroners do not have powers to conduct investigations into stillbirths. Some parents and charities have expressed concern at this and as part of the move to improve the investigation of and learning from stillbirths and neonatal deaths, the Government will consider how coroners could carry out an investigation into babies stillborn at term. The impact of this will be considered as part of an engagement process involving the Devolved Administration of Wales.

Following a consultation that closed in May 2017, the *Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury, a Summary of Responses* was published alongside the new announcements.[15] This has been supported by a commitment to continue to develop and refine the details of how the scheme could operate with a view to its establishment, ideally from April 2019.

The care received when a baby dies can have long-lasting impact on bereaved families, and high quality, compassionate and safe care can help parents through this devastating time. New funding from the DHSC has enabled Sands, the stillbirth and neonatal death charity, to develop a National Bereavement Care Pathway to help professionals provide high quality bereavement support to families after any pregnancy or baby loss. Draft guidance, published in October, is currently being piloted with a view to publishing the final guidance in 2018.[16]

More support for learning and quality improvement

Additional funding was announced for a new programme, Each Baby Counts Learn and Support. This new initiative between the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and NHS Improvement's Maternal and Neonatal Health Safety Collaborative, sets out to enable greater collaboration in order to align quality and safety improvement, multi-professional learning and clinical leadership into a consistent and sustainable system-wide safety strategy.

Incentivising best practice to improve safety

NHS Resolution has developed an incentivisation scheme into its Clinical Negligence Scheme for Trusts (CNST) pricing for 2018/19. Trusts that are able to demonstrate compliance with 10 clinical quality criteria will be entitled to at least a 10% reduction in their CNST maternity contribution. The ten criteria include drivers for improvements in both maternity and neonatal care. Further information will be provided in late January 2018.

The national preterm birth rate in England and Wales is 7.9%. In order to achieve the 2015 national ambition, additional measures, including a new ambition to reduce the rate of preterm births from 8% to 6% by 2025, have been announced. The details of this are still to be developed.

With the excellent progress made towards meeting the national ambition to reduce stillbirths, neonatal and maternal deaths and the additional funding and support, the timeframe for achieving the ambition has been brought forward by five years from 2030 to 2025.

The refreshed strategy will be delivered through the close partnerships between the DHSC, arm's-length bodies, the Royal Colleges and other national partner organisations, carefully coordinated through the Maternity Transformation Programme.

Meeting the national ambition will span the next eight-year period. Ongoing review and updating of plans will ensure current and emerging needs are met. The elements outlined in this article therefore reflect activity over the next 12-18 months. It is hoped that this short article highlights initiatives and opportunities to harness new investment to enhance care and safety for new and expectant mothers, newborns and families.

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