

Better Births Four Years On: A review of progress

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NHS England and NHS Improvement



Better Births Four Years On: A review of progress

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Executive Summary

Since the publication of *Better Births* in 2016 and of the *Report of the Morecambe Bay Investigation* in 2015, the NHS and its partners have come together through the national Maternity Transformation Programme to implement its vision for safer and more personalised care across England and deliver the national ambition to halve the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025. As we reach the fourth anniversary, this is an opportune time to take stock of progress, to reflect on successes and remaining challenges, and consider where further action is needed.

The data shows that good progress is being made over time in reducing perinatal and maternal mortality, despite an overall increase in the complexity of care.

There has been a 21% fall in the stillbirth rate between 2010-2018, meaning the NHS in England has met the 2020 20% reduction ambition two years ahead of schedule. There has been a reduction in the combined perinatal mortality rate of 15.1% reduction over the same period, also in line with the 2020 ambition. Maternal deaths, which are a very rare occurrence, are also falling. There has been 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.

At the same time, the latest women's experience survey shows a steady improvement nationally in what women say about their care. Over 17,000 women responded to the survey – of the 29 questions asked, 22 questions showed an improvement in score at national level, while just two questions showed a deterioration. This continues the trend we have seen since 2013 of improving experience. Importantly, women continue to feel more confident in the safety of the care they are receiving. 88% of women responded that they were given appropriate advice and support at the start of their labour when they contacted a midwife or the hospital, up by 1.5 percentage points since 2018 and 2.8 percentage points since 2013. 84% of women responded that if they raised a concern during labour or birth it was taken seriously, up by 2.5 percentage points since 2018 and 4 percentage points since 2013.

These improvements are being driven by the 44 Local Maternity Systems across the country, through which commissioners, providers, clinical teams and service users are redesigning services and delivering them to meet the needs of their communities. 10,000 women were booked on a continuity of care pathway in March 2019 (where they will see a midwife they know before, during and after birth). 130,000 women had access to a digital maternity record by December 2019, transforming how they access and own their information and how services can join up around them. And the new model of community hubs, which bring a range of

antenatal, postnatal and sometimes intrapartum care services together in one setting closer to women's homes, have been opened across the country, with over 100 new hubs opening by December 2019.

Support for women with perinatal mental health problems has increased. There is now a specialist perinatal mental health team operating in every local system across England. 700 new specialist staff were recruited to community services between 2017 and 2019, enabling over 13,000 more women to be seen in 2018/19. At the most specialist end, four new mother and baby units have opened in the areas of England most in need. The number of beds in existing mother and baby units has increased as well – nationally, including the new units, there has been a 40% increase in capacity since 2016, with over 150 beds now available. NHS England and Improvement is committed to further increasing the national capacity in these specialist units.

However, the picture is complex and in some areas it lacks clarity, partly as a result of data quality, and partly as a result of the time lag in the data. There are several areas for further action:

- To further understand the incidence of brain injuries, where a nationally consistent definition was only agreed in 2017. This is a priority, working with academics, clinicians, professional bodies, and organisations such as NHS Resolution and Healthcare Safety Investigation Branch (HSIB).
- Inequalities in outcomes from maternity services for women and babies must be tackled if we are to offer families the best start in life. The *NHS Long Term Plan* set out in January 2019 clear and costed plans to prioritise improvements in maternity services for the most vulnerable groups – Black, Asian and ethnic minority families, and those from the most deprived areas – particularly rolling out the continuity of carer service model to 75% of this group by March 2024. These improvements, and identifying how transformation can reduce health inequalities across all fronts, are key priorities for the Maternity Transformation Programme as it enters its next phase.
- Progress is being made on ambitions in relation to pre-term birth and supporting pregnant women who smoke to give up but now needs to accelerate.
- Whilst pregnancy and childbirth have in general never been safer, there is understandable public concern about the quality of care in a small number of individual units. NHS England and NHS Improvement is providing dedicated, on the ground improvement support to such units to work alongside their

clinical teams to make immediate improvements to care, and put in place the steps needed to transform their care in the coming months.

The change we have seen so far across England has come about as a result of the combined energy, vision and expertise of midwives, obstetricians, paediatricians, managers, commissioners and system leaders to implement the vision set out in *Better Births*. That activity has centred on the twin aims of making care safer and more personalised.

Improvement in safety is built around the PIER framework (prevention, identification, escalation and response). The “prevention” element in particular has delivered a range of universal initiatives focusing on changes to clinical practice and service models, and the development of a safety culture in provider trusts. A refreshed national maternity and neonatal safety improvement programme, with dedicated practical and communications support is being launched in March and April 2020, to ensure that themes emerging from learning nationally are turned universally into changes to clinical practice, behaviour and service models locally.

The “identification” and “escalation” elements have been in place as part of wider quality governance and oversight functions, and are being strengthened by the addition of a maternity-specific lens which can support effective surveillance at local, regional and national levels. The Maternity Safety Support Programme, which forms the “response” element, has a track record of helping provider trusts to improve the quality of their care, and is being further developed and strengthened with additional resource.

Improvement in personalisation, which evidence tells us will also contribute to improving safety, is built around a number of tools and processes to support and empower women to make decisions about their care, including continuity of carer and personalised care and support planning. There is a particular focus on postnatal care, where we know that there has been less focus and investment, and so several service developments are due to be implemented in 2020.

Going forward, the programme will continue to work in partnership with national organisations and local systems to harness the collective drive and will to change and improve maternity care for women and families. Local Maternity Systems will continue to be the agents for change, and national support will focus on helping them to deliver evidence-based improvements to care rapidly and consistently.

Introduction

1. Since the publication in 2016 of *Better Births: Improving outcomes of maternity services in England*¹ and in 2015 of the *Report of the Morecambe Bay Investigation*,² the NHS and its partners have come together through the national Maternity Transformation Programme to implement its vision for safer and more personalised care across England and deliver the national ambition to halve the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025.
2. Over the last four years, we have seen clinical teams, provider organisations, commissioners and regional and national bodies work together to design and deliver improved maternity services across England. 44 Local Maternity Systems have been working together to plan and implement local changes to deliver the *Better Births* vision.
3. At the same time, cases in a small number of providers have come to light where care has fallen well short of the standard that is expected, with devastating effects on the families involved. Action is being taken with those provider organisations to ensure that lessons are learnt from these cases, that care is improved, and that these mistakes do not happen again, whilst ensuring that all provider organisations have the support they need to develop the leadership and culture which are a prerequisite for the safest care.
4. This anniversary is therefore an opportune time to take stock of progress, to reflect on successes and where problems have arisen, and consider where further action is needed to realise opportunities and to move further faster towards our shared goal of securing outcomes from maternity care that are amongst the best in the world.
5. This report provides analysis of the improvements that have been made in terms of outcomes for women and their babies, experience of care, and overall quality of services following the publication of *Better Births*. It also identifies where there is variation and suggests why this is the case.
6. The report summarises the actions that have taken place across the country to secure these improvements, and outlines action that will be taken in the coming years to further improve outcomes and reduce unwarranted variation.

¹ <https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/>

² <https://www.gov.uk/government/publications/morecambe-bay-investigation-report>

How is care improving?

7. This chapter sets out what is known about improvements to outcomes, women's experience of care and what staff are telling us, and identified variation.
8. There are challenges in understanding outcomes data as it has a relatively long time lag. For the data on service quality, a new and vastly improved Maternity Services Dataset is being rolled out across the country, however data quality is not yet complete and for some indicators has not been collected for long enough to judge trends over time. Nevertheless, there is still a significant amount of data available about the quality and outcomes of maternity services, and this report has focussed on key indicators where there is good data upon which we can draw conclusions.

Changing complexity of the women we care for

9. In considering our progress in improving care, it is important to first understand the changing nature of the health and demographics of the women and families that maternity services are caring for. Figures suggest that a greater proportion of pregnant women are older, overweight or have underlying health conditions than previously.
10. This means that the complexity of the maternity care the NHS is providing has increased. For example:
 - More than half of women (50.4%) with a recorded BMI at booking in 2016/17 were overweight or obese (up from 47.3% in 2015/16).³
 - The proportion of mothers aged 35 years or older at birth in England and Wales has increased year on year from 19.9% in 2010 to 23.4% in 2018, which continues a long term upward trend since the 1970s⁴.
 - The proportion of deliveries complicated by diabetes mellitus has increased from 5% to 8% between 2013-14 and 2018-19. While this increase may be linked to increases in maternal obesity it may also partly be an indication of improved identification and recording of the condition during pregnancy⁵.

³ National Maternity and Perinatal Audit: <https://maternityaudit.org.uk/pages/cr2019km>

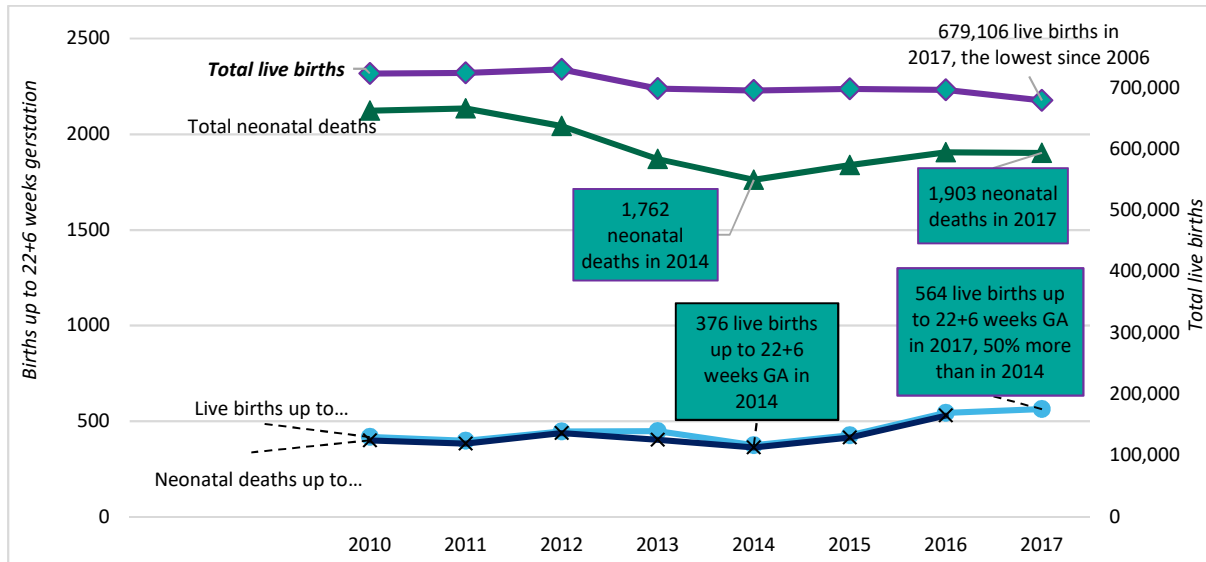
⁴ [ONS - Births by Parents' Characteristics, England and Wales](#)

⁵ [NHS Maternity Statistics, England 2018-19 \[PAS\]](#)

Outcomes: progress against the national safety ambition

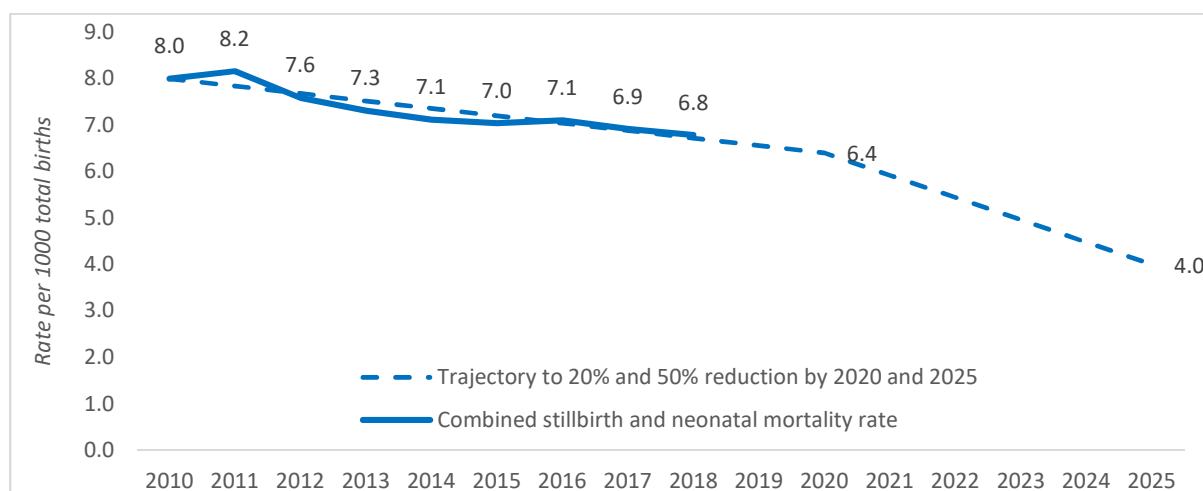
11. The NHS has a national ambition to halve the rates of stillbirths, neonatal deaths, maternal deaths and brain injuries during birth by 2025, from a 2010 baseline. This was brought forward from a previous target date of 2030. In addition, the NHS is working towards an interim ambition of a 20% reduction by 2020.
12. The national ambitions for stillbirth rate and neonatal mortality rate are monitored using data in the Office for National Statistics (ONS) Childhood Mortality Statistics publication, which are based on information recorded when deaths are certified and registered. This publication is based on an annual extract of data on deaths occurring in the calendar year, which is taken approximately 10 to 11 months after the end of the data year to allow for late registrations. ONS Childhood Mortality statistics are generally published around 13 to 16 months after the data period, with the most recent data available being for 2018 (published on 20 February 2020). The NHS also tracks data prepared by the University of Oxford's National Perinatal Epidemiology Unit (NPEU) for its Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports. Annual Stillbirth and Neonatal Mortality Rates for 2013 to 2017 are published in MBRRACE-UK's Perinatal Mortality Surveillance Reports. Perinatal mortality rates published by MBRRACE are informed by ONS data on births and deaths and are therefore published later than the ONS Childhood mortality statistics publication.
13. Between 2010 and 2018 there was a 21% fall in the **stillbirth** rate. This means the NHS in England has met the 2020 20% reduction ambition two years ahead of schedule (although the trajectory will need to improve to meet the 50% ambition by 2025).
14. Between 2010 and 2018 the **neonatal mortality** rate fell by 5.1%. On the face of it this is below the trajectory required to achieve the national ambition. However, between 2014 and 2017 the number of very low gestational age babies (i.e., babies born at a gestational age of less than 23 weeks) born alive rose by 50% (see figure 1). These babies have a very low chance of survival. It is possible that this trend is in part due to a change in the threshold for actively assessing for signs of life before 24 weeks' gestation thereby converting the classification of a pregnancy loss before 24 weeks from a miscarriage to a neonatal death.

Figure 1. The total number of live births has reduced in recent years but the numbers of live births at up to 22+6 weeks gestational age showed a 50% increase from 2014 to 2017 ((Data Source: Office for National Statistics – [Child and Infant Mortality in England and Wales](#))



15. The latest ONS Childhood Mortality Statistics publication includes analysis of neonatal mortality rates for babies born at 24 weeks' gestational age or over. This provides a more consistent metric against the 2010 baseline. The neonatal mortality rate for England and Wales reduced by 20% from 2.0 to 1.6 per 1000 live births between 2010 and 2017. The improvement occurred between 2010 and 2014, since which the rate has remained at 1.6 per 1000 live births up to 2017.
16. The survival of some babies to birth may be the result of increased efforts to reduce stillbirths. Therefore, a more accurate understanding may be obtained by combining the stillbirth and neonatal death rate into one indicator. Figure 2 shows that the reduction in the combined perinatal mortality rate is broadly on a trajectory to meet the ambition (a 15.1% reduction between 2010 and 2018 against the 2020 ambition trajectory of a 16.3% reduction).

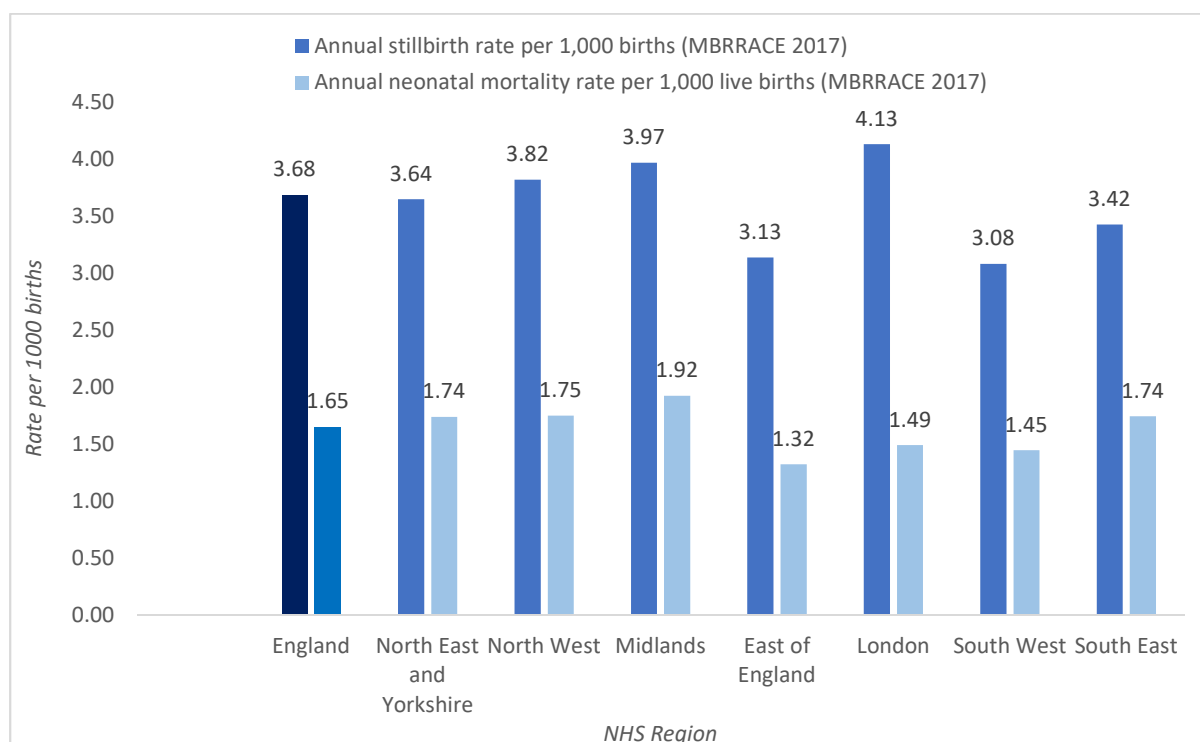
Figure 2. The combined rate of stillbirth and neonatal mortality per 1000 total births is broadly in line with the trajectory to meet a 20% reduction since 2010 by 2020. (Data Source: Office for National Statistics – [Child and Infant Mortality in England and Wales](#))



17. Mortality rates remain higher for Black or Black British and Asian or Asian British babies. Whilst stillbirth rates for these groups have reduced over the period 2015 to 2017 from 8.17 to 7.46 and from 5.88 to 5.70 per 1,000 total births respectively, neonatal mortality rates have increased over the same period from 2.45 to 2.77 and from 2.50 to 2.86 per 1,000 live births respectively.

18. At NHS region level, MBRRACE crude (unadjusted) figures show variation in stillbirth rate from 3.08 per 1000 births in the South West to 4.13 per 1000 births in London; while neonatal mortality rates vary from 1.32 per 1000 live births in the East of England to 1.92 per 1000 live births in the Midlands (See figure 3). Part of this variation may be explained by differences in clinical risk and demographic factors.

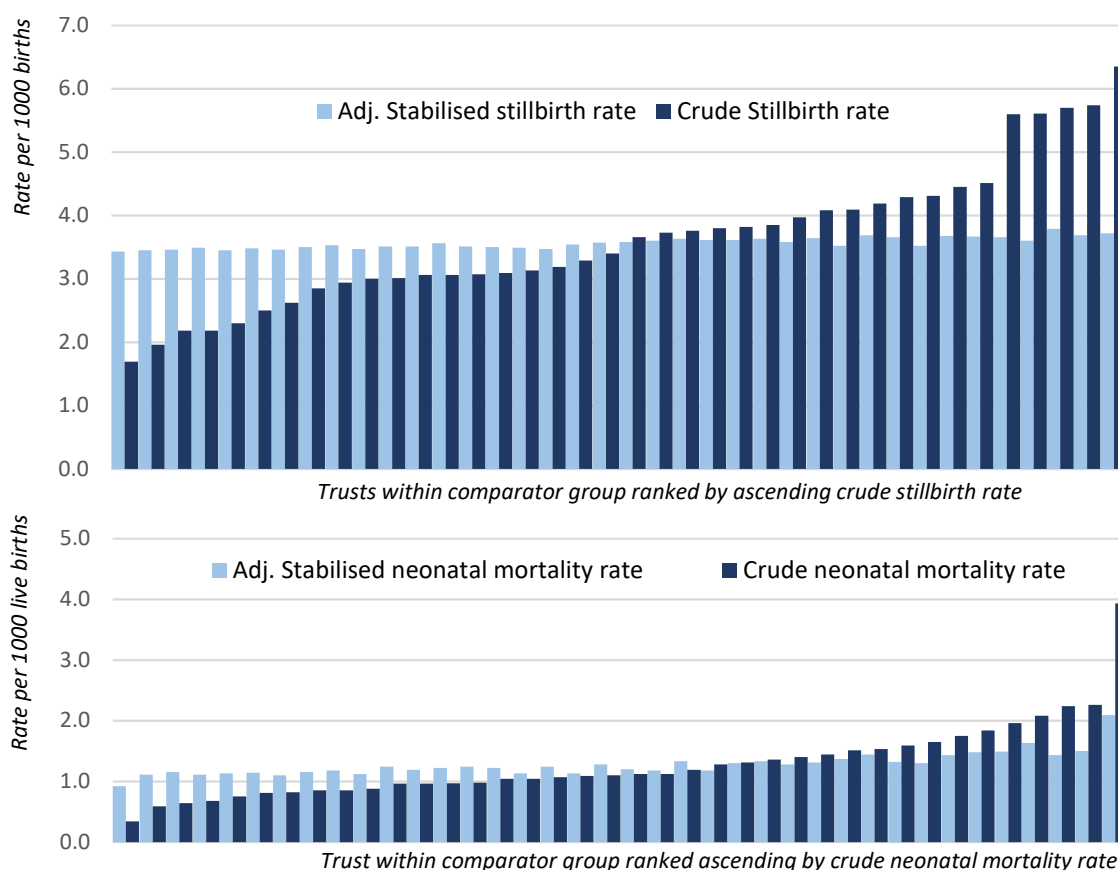
Figure 3. There is variation in crude perinatal mortality rates at NHS region level, some of which may be due to differences in clinical risk and demographic factors (Data source: Aggregated from [MBRRACE – UK Perinatal Mortality Surveillance Report 2017](#))



19. There is variation between trusts in crude (unadjusted) perinatal mortality rates. However, some caution is needed in interpreting differences in crude rates between trusts due to small numbers and differences in case-mix. Variation reduces significantly after adjustment for clinical risk and demographic factors and stabilisation to account for statistical noise. For example, in trusts with 4,000 or more births at more than 24 weeks' gestational age per annum⁶, there is 3.8 fold variation in crude rates of stillbirth (from 1.69 to 6.35 per 1000 births) and 11.6 fold variation in crude rates of neonatal mortality (from 0.34 and 3.93 per 1000 live births). When rates are adjusted and stabilised to account for clinical risk, demographic factors and natural variation over time, variation is reduced to 1.1 fold for stillbirth rate and 2.3 fold for neonatal mortality rate.

⁶ There are 42 trusts within this group. The assessment of variation excludes four trusts for which crude rates have been suppressed due to small numbers

Figure 4. Variation is reduced considerably when perinatal mortality rates are adjusted for clinical risk factors, demographic factors and stabilised to account for natural variation (Stabilised and adjusted stillbirth rate and neonatal mortality rate for trusts with more than 4000 births at 24+0 weeks gestation age or greater: [MBRRACE – UK Perinatal Mortality Surveillance Report 2017](#))



20. **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.

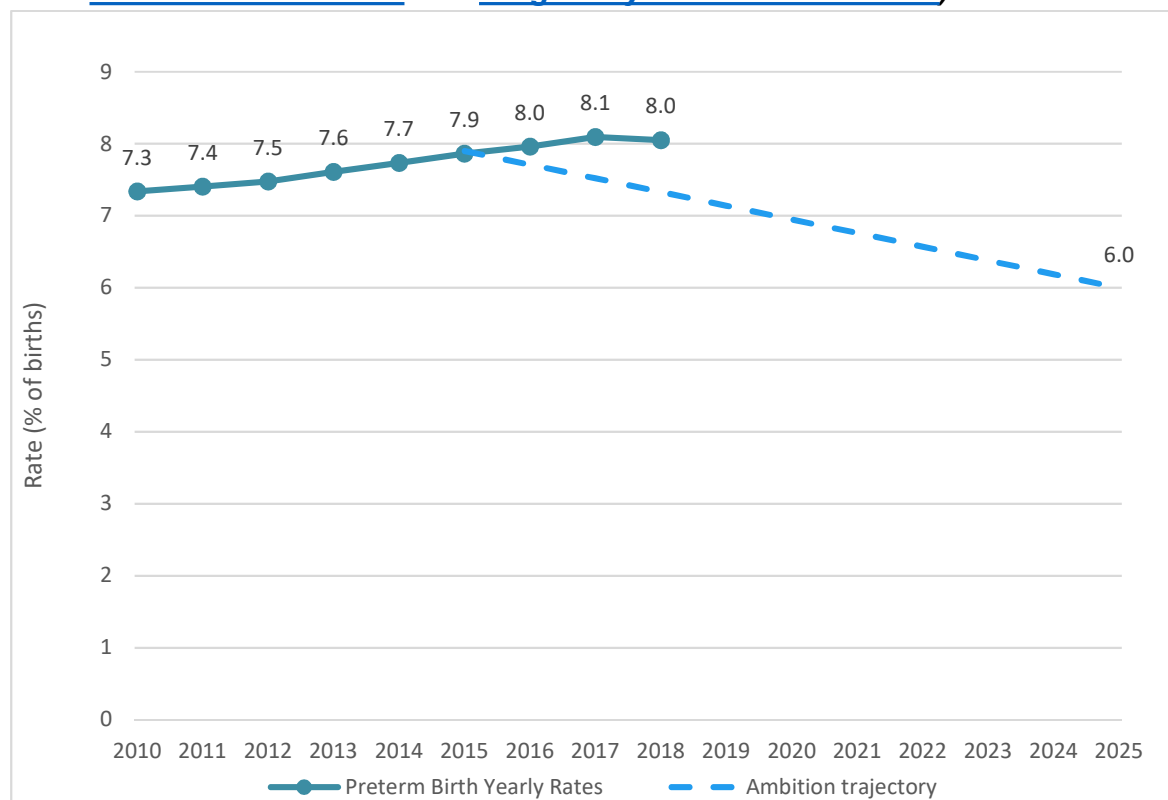
21. The National Neonatal Research Database (NNRD) is the data source for **brain injury** data, although a definition of brain injury was agreed nationally and published only in March 2017. In addition, in 2010–2011 population coverage in the database was incomplete, so the earliest year we have a robust national estimate of the serious brain injury rate for is 2012. The data show the rate of

serious brain injuries fell from 5.4 per 1000 in 2014 to 5.1 per 1000 births in 2017, having previously increased from 4.9 in 2012. However, this trend was created retrospectively. This means that before publication of the definition, the NHS could not routinely and consistently monitor incidents, nor put in place properly targeted improvements to care, although the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts⁷ reports have been providing recommendations and findings relating to serious brain injuries at term since 2015. In addition, although good care can reduce the risk of a baby's brain not receiving enough oxygen during birth (hypoxic ischaemic encephalopathy), the definition also incorporates other causes of brain injury. In short, the picture of what is happening to rates of brain injury has been unclear, and will improve over time as the NHS monitors progress against a common definition and takes action to improve care. In the meantime, considerable insight has been generated into which improvements to care are most likely to have an impact on reducing brain injuries.

22. The national ambition for the **pre-term birth** rate is a reduction from 8% in 2015 to 6% by 2025. The pre-term birth rate rose steadily from 7.3% in 2010 to 8.1% in 2017 and then fell to 8.0% in 2018. The impact of programme initiatives to tackle pre-term birth are expected to have an impact soon, particularly the new fifth element of the Saving Babies' Lives care bundle (see paragraph 61).

⁷ <https://www.rcog.org.uk/eachbabycounts>

Figure 5. Preterm Birth Rates in England have been rising steadily in recent years but fell slightly between 2017 and 2018. A continued more rapid reduction is required in order to meet the 2025 ambition. (Data sources: ONS [Birth Characteristics](#) and [Pregnancy and Ethnic Factors](#))



23. An additional national ambition comes in *Smoke-free generation: tobacco control plan for England*.⁸ This sets an ambition for the proportion of **mothers who are smokers** at the time they give birth to be 6% by the end of 2022. Maternal smoking is strongly associated with increased risk of perinatal mortality and pre-term birth. The number of mothers who smoke has been reducing over a long period of time to reach 10.6% in 2018/19, but the trajectory will need to improve to reach the 2022 target (See figure 6).

24. At NHS England Region level, maternal smoking rates range from 4.8% in London to 14.8% in North East and Yorkshire (See figure 7). The geographical trend in maternal smoking rates correlates with overall smoking rates.

⁸ <https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england>

Figure 6. Rates of maternal smoking at time of delivery are on a downward trend but the pace of reduction needs improve to meet the national ambition (Data source: [NHS Digital SATOD collection](#))

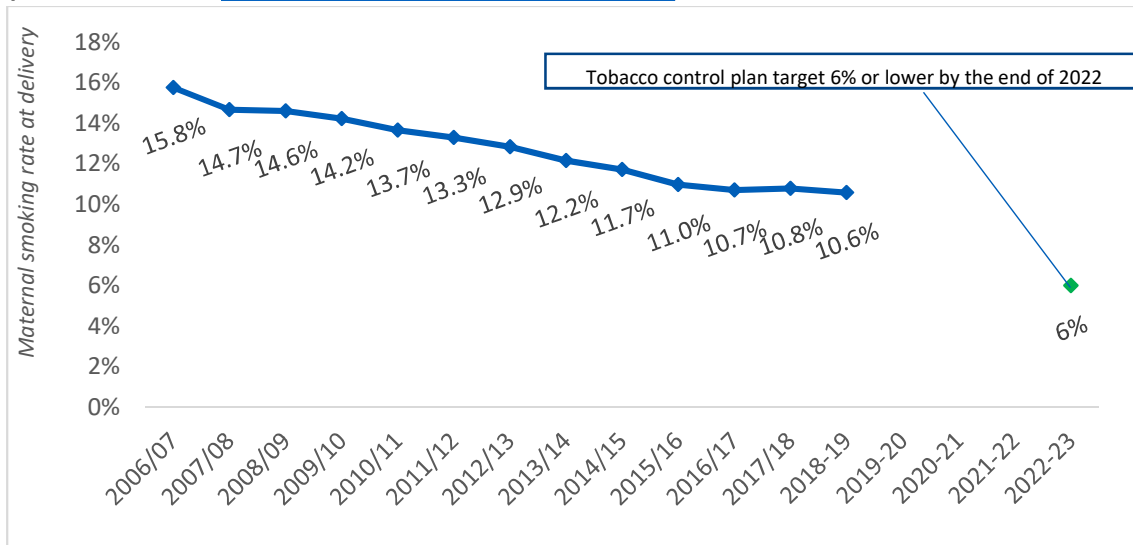
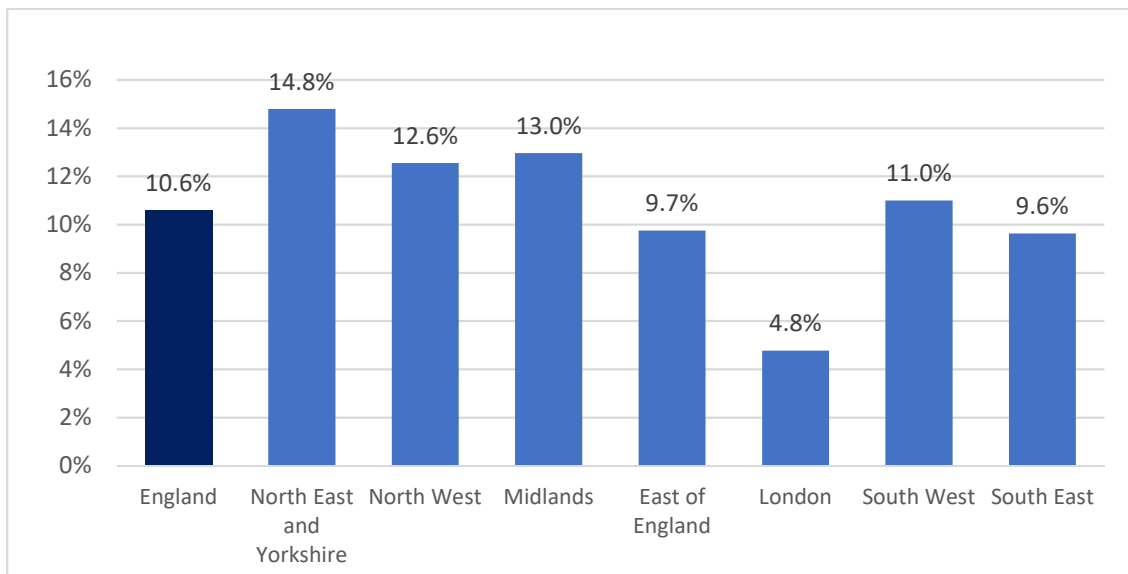


Figure 7. The proportion of women who are recorded as being a 'smoker' at the time of delivery varies from 4.8% in London to 14.8% in North East and Yorkshire (Data source: Aggregated from [NHS Digital SATOD 2019/20 Quarter 1](#))



Quality of care

25. Other clinical indicators can help to improve understanding of the picture of the quality of care both nationally and locally, but care needs to be taken because with some indicators there is not an optimum number and both high and low outliers may be a cause for further investigation.
26. Best practice, as outlined in *Better Births*,⁹ is for the local NHS to use the information to a) identify where they are outliers, b) then to investigate further what the reasons are for being an outlier, and c) where sensible to make changes to local clinical practice and service models. This requires a sophisticated approach, sometimes triangulating multiple sources of data to reach a conclusion. For example, the caesarean section rate on its own says very little about the quality of a service, but in combination with other quantitative data, qualitative information and service user feedback it may be possible to draw conclusions about whether the balance between different interventions is broadly right.
27. Analysis of clinical indicators such as the National and Maternal Perinatal Audit (NMPA) Clinical Reports relies on the quality of data submitted. While the NMPA reported that the quality and completeness of data submitted had improved between the 2015/16 and 2016/17 reporting years, many trusts and boards were excluded from one or more measures owing to poor data quality and completeness.
28. Method of onset describes the means by which labour begins. Onset of labour without pharmacological, mechanical, or operative intervention, is most common as a proportion of total deliveries but has decreased from **69%** in 2008-09 to **50%** in 2018-19. **Induction of labour** is offered to a woman if her baby is overdue or there is a risk to her or her baby's health. The proportion of births where the method of onset is induction increased from **20 per cent** to **33 per cent** in the period 2008-09 to 2018-19 (NHS Digital 2018-19 Maternity Statistics). The NMPA Clinical Report 2019 found that substantial variation remained in the rates of key measures of maternity care such as induction of labour and modes of birth, beyond what can be explained by clinical risk and demographic factors. This suggests that there remains variation in clinical practice, decision making and outcomes. This may in part be explained by recent research which has provided compelling evidence that induction of labour at 39 weeks reduces the risk of caesarean section and prolongation of pregnancy after 41 weeks is associated with a higher stillbirth rate. This information has led to a change in practice about when induction of labour is offered with the possibility that more women opt for induction of labour once they have been given the material facts.

⁹ *Better Births*, paragraph 4.84

29. **Caesarean** birth occurs for many reasons. Elective (planned) caesarean birth is offered for a range of conditions. Women with previous caesareans are offered the option of a caesarean birth. A caesarean may also be offered if the baby is not in the cephalic (head down) position, if there are concerns about the baby’s wellbeing or growth, or some maternal conditions including maternal mental health needs. A small number of caesarean sections occur due to mothers requesting this mode of birth. An emergency (unplanned) caesarean section may be performed when there are acute concerns about the baby’s or mother’s wellbeing or when labour is not progressing. A caesarean is a major operation that carries a number of risks, so it is usually only carried out if it is the safest option for the woman and her baby. Accordingly, both high and low numbers of caesarean sections may warrant local investigation to understand the reasons.

30. Annual NHS Maternity Statistics for 2018-19 show a continuation of the increase in emergency and elective c-sections and the corresponding reduction in spontaneous deliveries. At the same time there has been a small decrease in the number of instrumental births (assisted using a ventouse or forceps).

Figure 8a. The most common delivery method is spontaneous vertex, however this shows a decreasing recent trend (Data source: [NHS Digital Annual Maternity Statistics 2018-19](#))

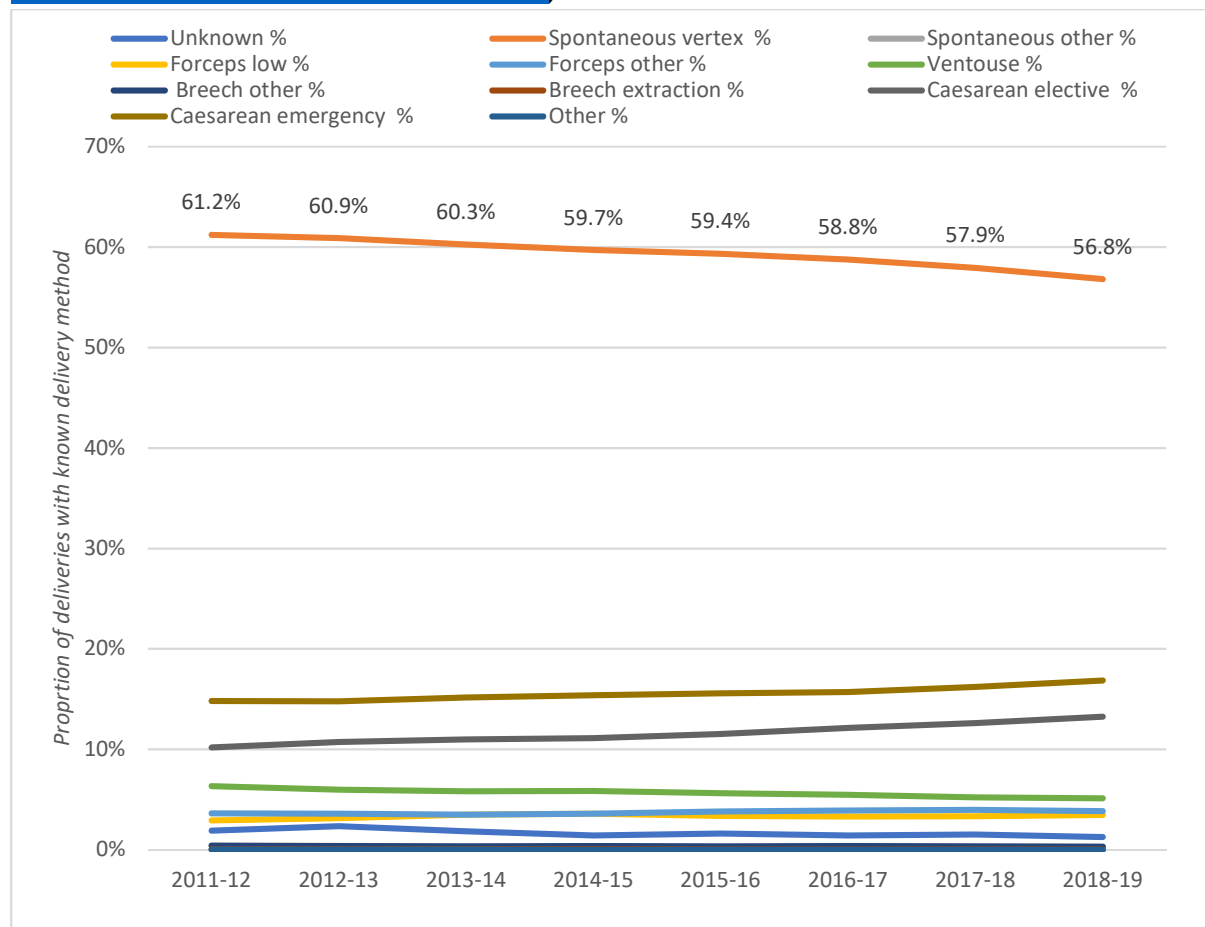
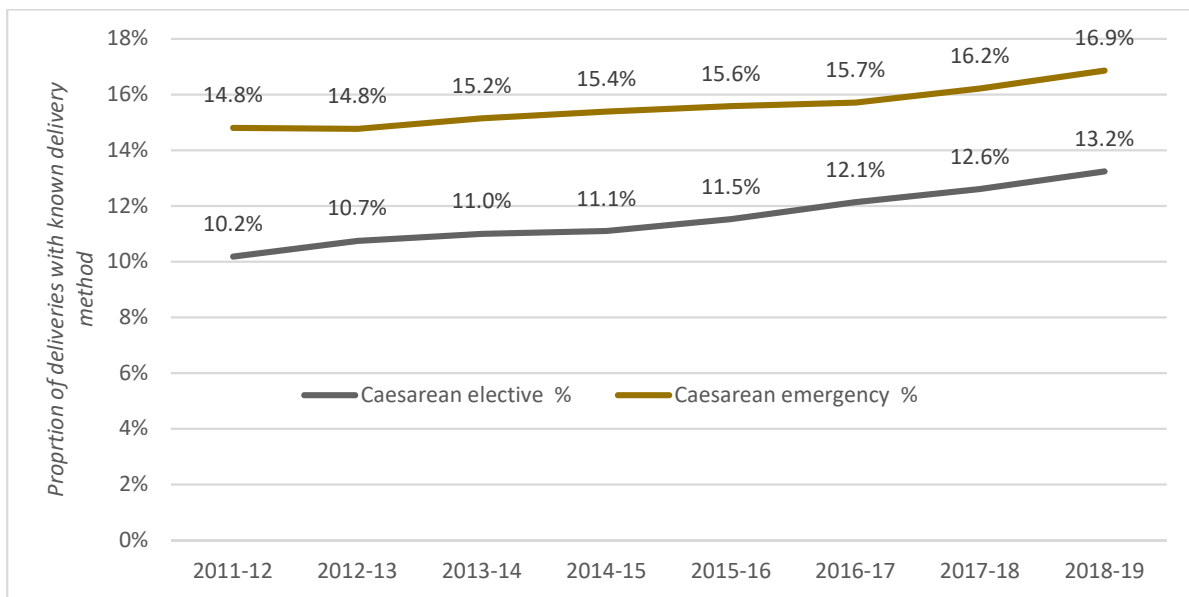
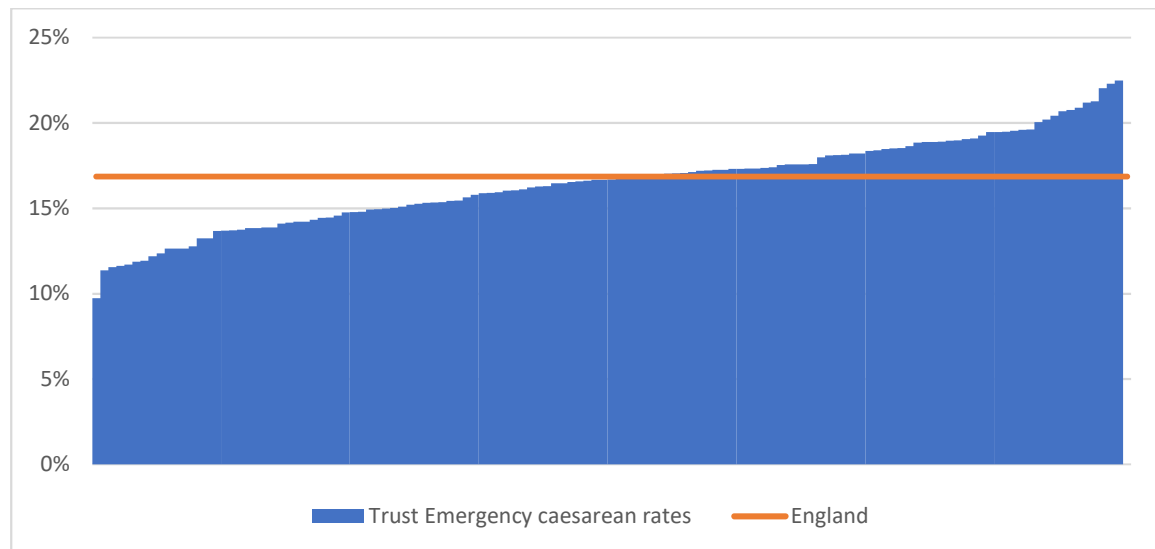


Figure 8b. There have been corresponding steady increases in rates of elective and emergency caesarean deliveries (Data source: [NHS Digital Annual Maternity Statistics 2018-19](#))



31. The increase in the number of inductions and the increase in caesarean sections shows that in general the number of medical interventions is increasing. There remains variation locally.

Figure 9. Emergency caesarean rates at NHS trust level range from 9.7% to 22.5%. (Data source: [NHS Digital Annual Maternity Statistics 2018-19](#))

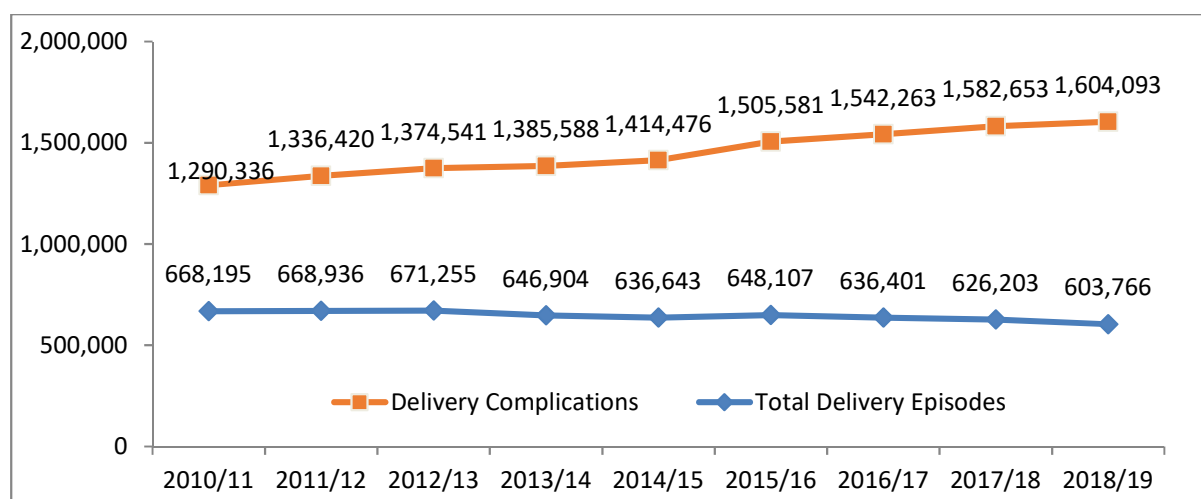


32. The number of complications recorded during labour and birth shows year on year increases.¹⁰ The majority of the increase since 2013-14 is due to a rise in the recorded numbers of the following three complications:

- maternal care for known suspected fetal problems;
- other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium;¹¹ and
- postpartum haemorrhage.

Figure 10. An increasing number of delivery complications against a reduction in total deliveries is likely linked to improved detection and recording and an increase in complexity.

(Data source: [NHS Digital Annual Maternity Statistics 2018-19](#))



33. The increase in these complications seems most likely to be linked to improved detection (at delivery or earlier) and recording, prompted by policy initiatives and clinical audit findings.

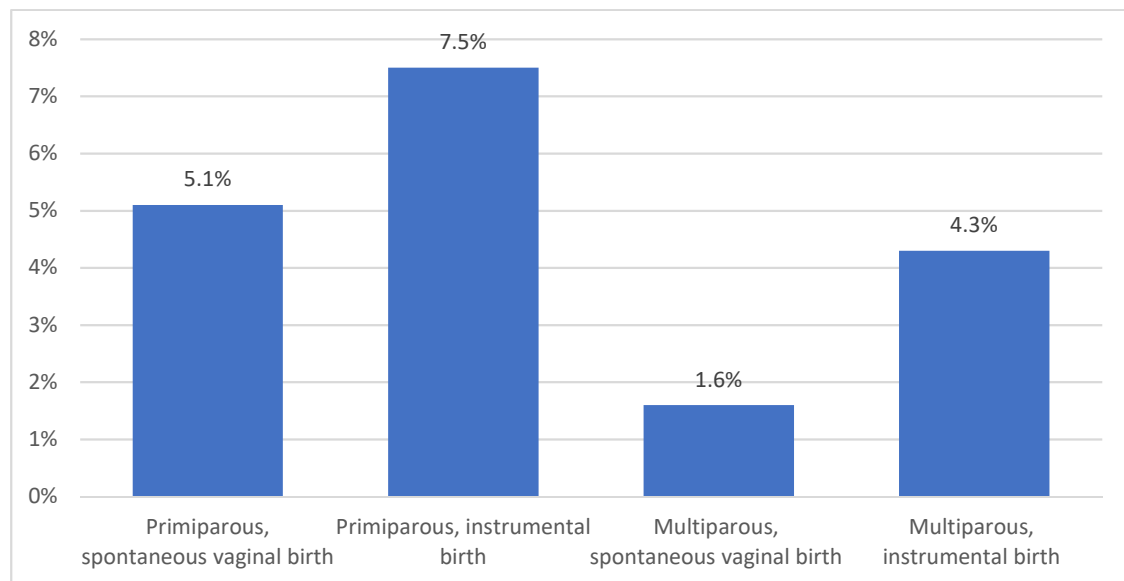
34. It is common for the perineum to tear to some extent during childbirth. For most women, these tears are minor and heal quickly. However, for some women the tear may be deeper. Third- or fourth- degree **perineal tears** extend into the muscle that controls the anus (anal sphincter) and are described as Obstetric Anal Sphincter Injury (OASI). Recognition and appropriate repair of OASI reduces long-term morbidity such as incontinence. NHS maternity services will therefore want to keep the incidence of OASI low, through interventions such as the RCOG OASI Care Bundle, but detection rates high to ensure appropriate management.

¹⁰ Source: Hospital Episode Statistics [NHS Digital Annual Maternity Statistics Publications](#) 2010/11 to 2018/19

¹¹ International Classification of Diseases: <https://www.icd10data.com/ICD10CM/Codes/O00-O9A/O94-O9A/O99->

35. In England, the adjusted rate of third or fourth degree perineal tears for term vaginal births in 2016-17 was 3.4%. There is a higher rate of third or fourth degree tears in primiparous women and instrumental births. (See figure 11)¹²

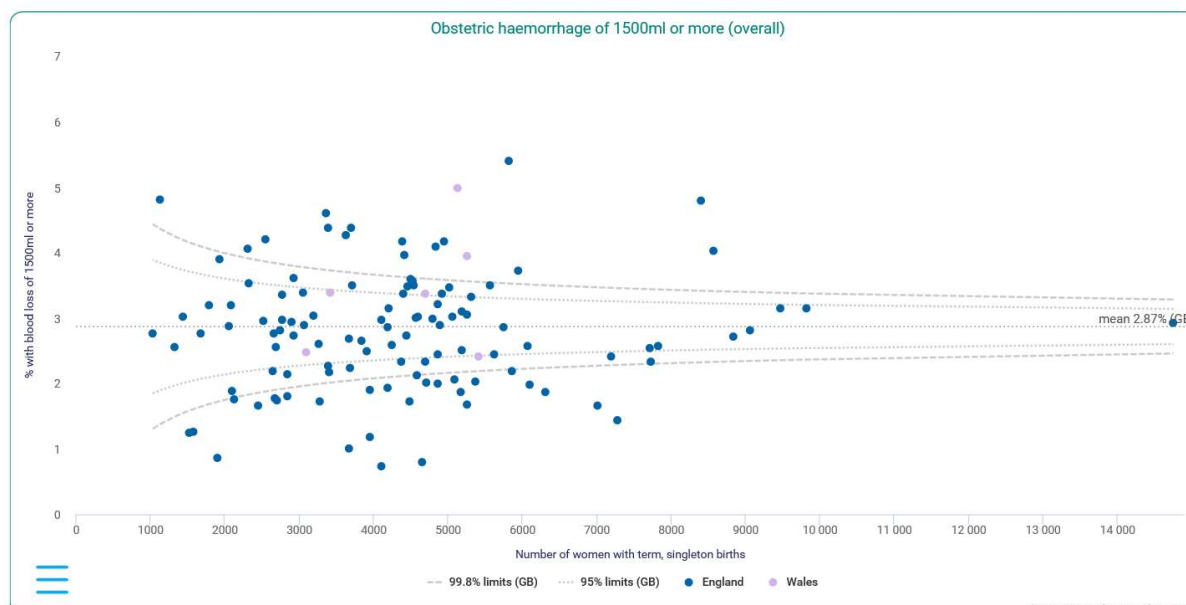
Figure 11. Rates of third or fourth degree perineal tears are highest in primiparous women who have and instrumental birth. (Data source: [National Maternal and Perinatal Audit based on 2016-17 Hospital Episode Statistics](#))



36. Postpartum haemorrhage (PPH) is a major source of ill health after childbirth and can cause serious illness for the mother or, rarely, death. NHS maternity services will therefore want to keep their rates low. The most common cause of any PPH is the womb not contracting down after birth. This is more likely in women who are obese, have a multiple birth or large baby, have a prolonged labour or caesarean section, or have had a haemorrhage before. For the purposes of identifying outliers, a threshold of 1500ml of blood loss is used as this is associated with longer stays in hospital, and a higher chance of needing a blood transfusion, a further operation or intensive care. There remains variation, beyond that which would be expected, in the proportion of women reported as having a PPH of 1500 ml or more. This may be due to variation in the incidence of PPH or the implementation of recommendations from MBRRACE about better assessment of blood loss, which results in more women receiving the appropriate care.

¹² Rate for women who gave birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks gestation. The rates are adjusted for case mix.

Figure 12. There is variation at trust level in rates of Postpartum Haemorrhage beyond what can be explained by differences in case-mix alone. (Data source: [National Maternal and Perinatal Audit based on 2016-17 Hospital Episode Statistics](#))



Experience: what women say about the care they receive

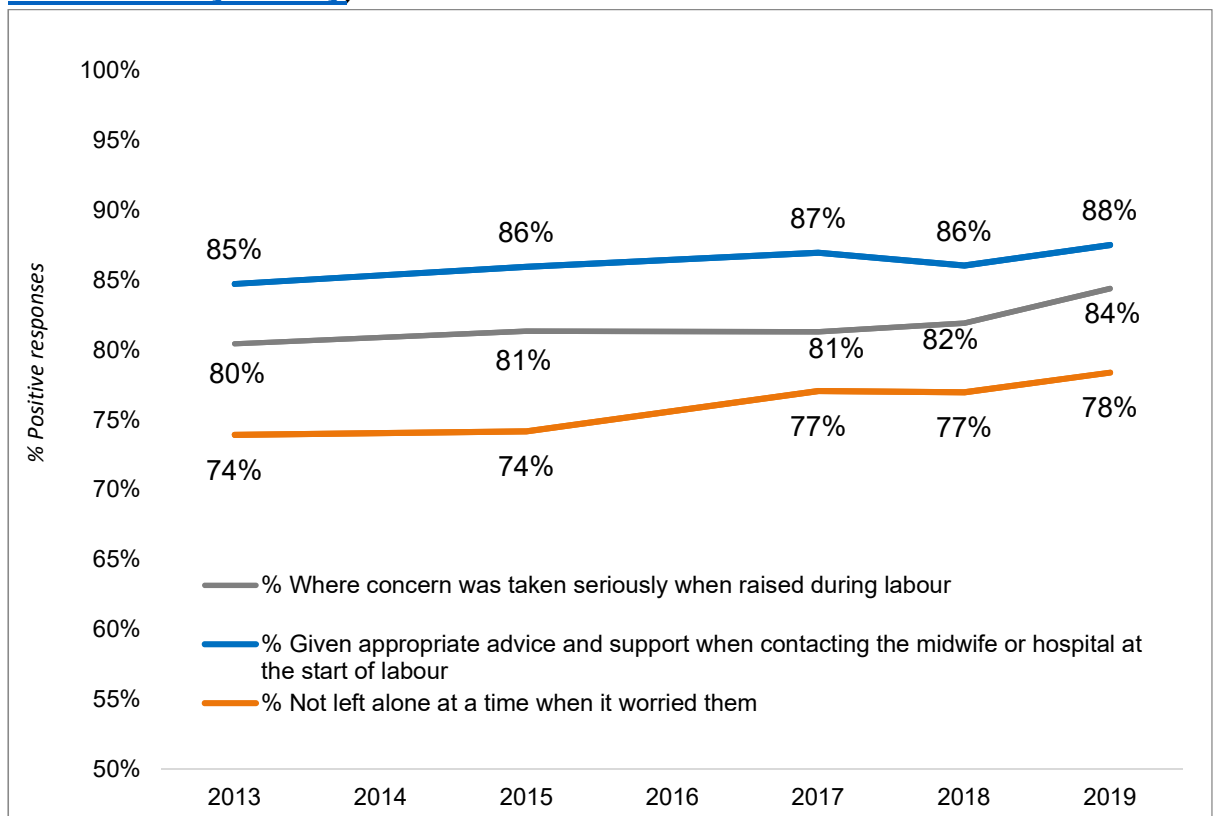
37. As well as the clinical data, how women feel about the care they receive is a vital source of information about quality. The Care Quality Commission (CQC) undertakes an annual survey of the users of maternity services. The latest survey had 17,151 responses, providing a valuable source of insight and information both nationally but also on a provider by provider basis, allowing comparison and learning between services.

38. The 2019 survey results are positive, showing that the vast majority of women had a good experience of maternity care. Moreover, the trend is also positive, with statistically significant improvements seen between 2018 and 2019 across most comparable questions, with some positive changes being relatively large when compared with other patient experience survey results in recent years. There are 29 questions in the survey which are scored by CQC for the purposes of benchmarking trust performance; and for which the score is comparable between 2018 and 2019 survey results. Of these questions 22 questions showed an improvement in score at national level, while just two questions showed a deterioration.

39. The 2019 results show that most women have confidence in the safety of the care they are receiving, and that this confidence is growing. Relevant questions which are comparable over time are:

- 88% of women responded that they were given appropriate advice and support at the start of their labour when they contacted a midwife or the hospital, up by 1.5 percentage points since 2018 (86%) and 2.8 percentage points since 2013 (85%).
- 84% of percent of women responded that if they raised a concern during labour or birth it was taken seriously, up by 2.5 percentage points since 2018 (82%) and 4 percentage points since 2013.
- 78% of women reported that they (and / or their partner or a companion) were not left alone at all at a time when it worried them during labour, birth or shortly after birth. This is up by 1.4 percentage points since 2018 (77%) and 4.5 percentage points since 2013 (74%).

Figure 13. An increasing proportion of women report that they have confidence in the safety of the care they are receiving. (Data source: [2019 CQC Maternity Survey](#))



40. However, there is still room for improvement in the results of questions about midwives' awareness of women's medical history (see figures 14a and 14b). This is expected to improve as continuity of carer is rolled out further (as described in paragraph 47).

Figure 14a. Women’s perception of midwives’ awareness of their medical history during the antenatal care shows that there is room for improvement in this aspect of women’s care. (Data source: [2019 CQC Maternity Survey](#))

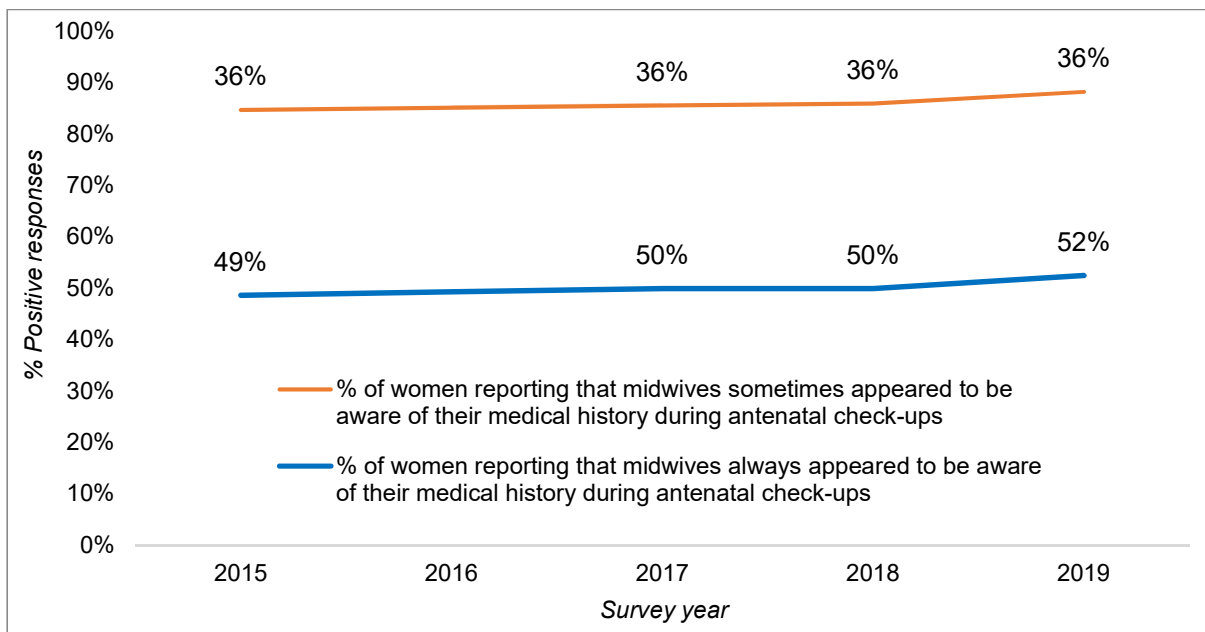
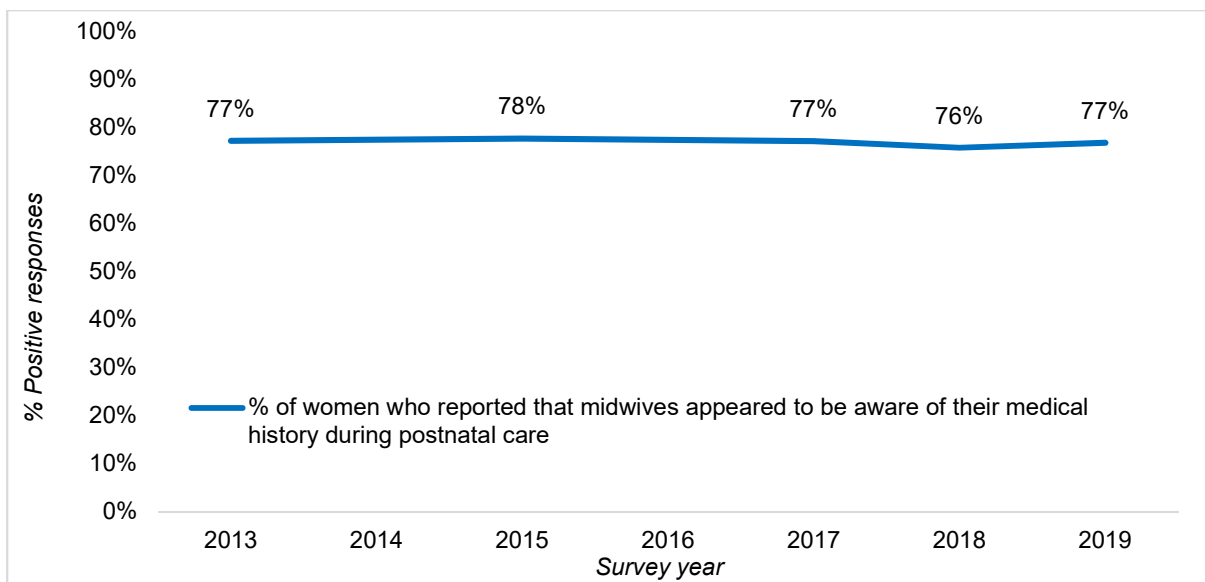
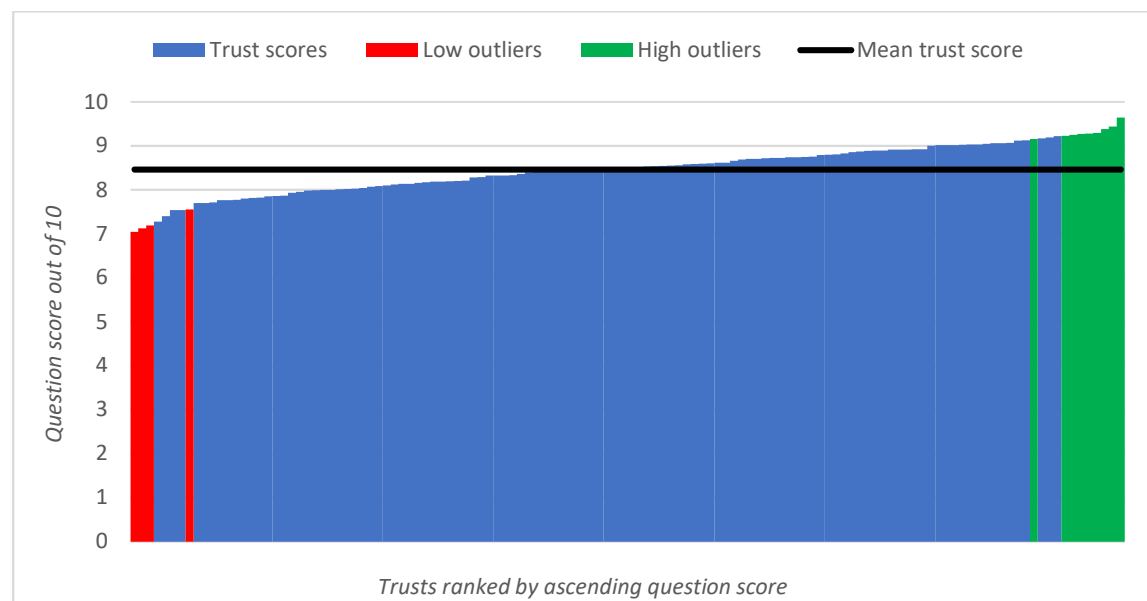


Figure 14b. Women’s perception of midwives’ awareness of their medical history during the postnatal care shows that there is also room for improvement in this aspect of women’s care. (Data source: [2019 CQC Maternity Survey](#))



41. There also remains significant variations in the scores received by individual trusts, for example on whether women felt their concerns during labour were being taken seriously, with potential lessons to be learnt by low outliers from high outliers.

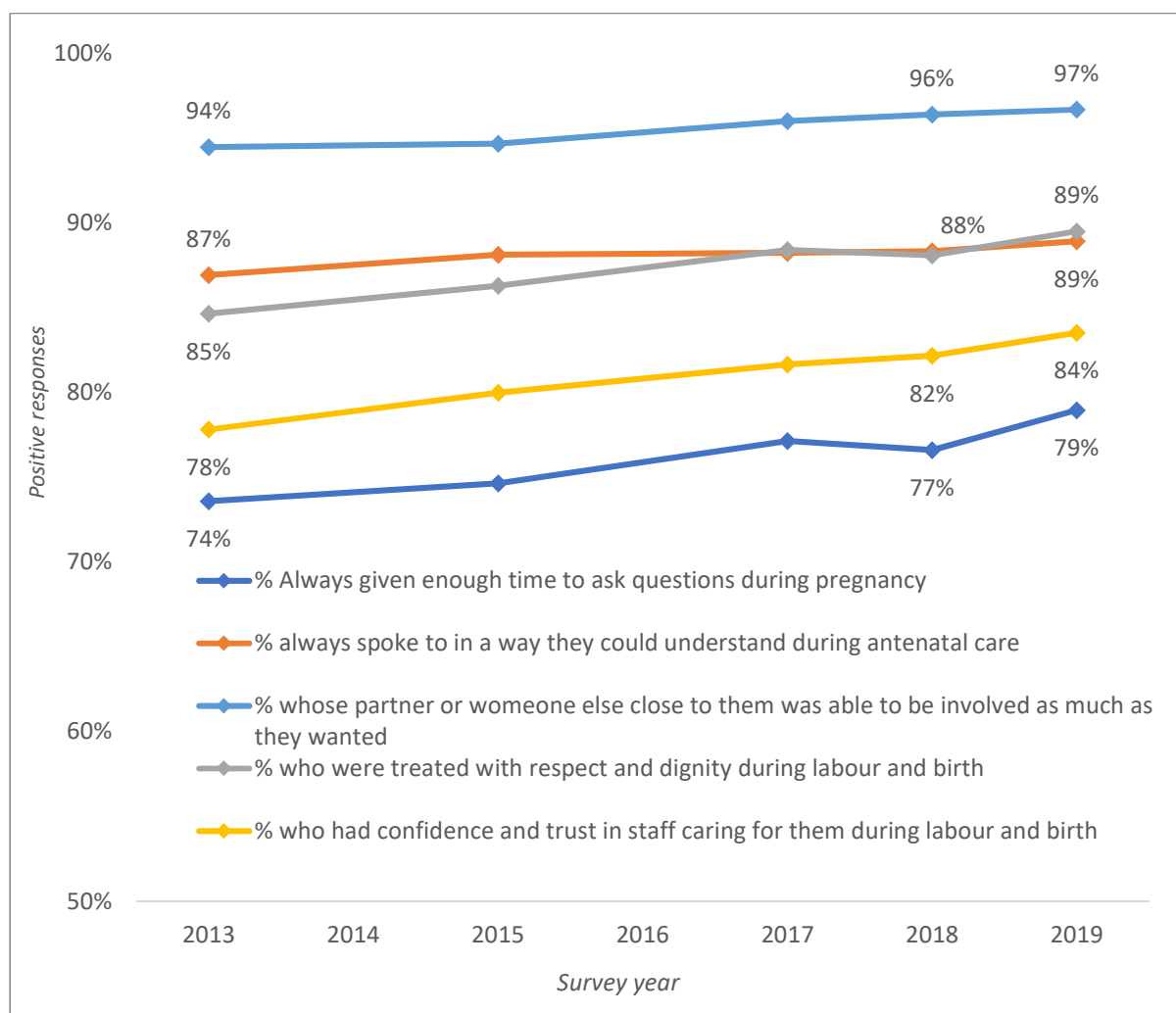
Figure 15. There is notable trust level variation in women’s responses about whether concerns they raised during labour and birth were taken seriously (Data source: [2019 CQC Maternity Survey](#))



42. On personalisation of care, too, there are some positive results:

- 82% of women responded that they were ‘always’ involved in decisions about their care during antenatal check-ups. Only 2% of women responded that they were not involved.
- 79% of women reported that they were ‘always’ given enough time to ask questions or discuss their pregnancy during antenatal check-ups, up by 2.4 percentage points since 2018 (77%).
- 90% of women responded that they were ‘always’ spoken to in a way they could understand, up by 1.3 percentage points since 2018 (88%).
- 97% of women responded that their partner, or someone else close to them involved in their care, was able to be involved as much as they wanted.
- 89% of women responded that they were ‘always’ treated with respect and dignity, up by 1.4 percentage points since 2018 (88%).
- 84% of women responded that they ‘definitely’ had confidence and trust in the staff caring for them, up by 1.4 percentage points since 2018 (82%).

Figure 16. There are positive results showing improvement over time in women’s responses to questions about the personalisation of their care. (Data source: [2019 CQC Maternity Survey](#))

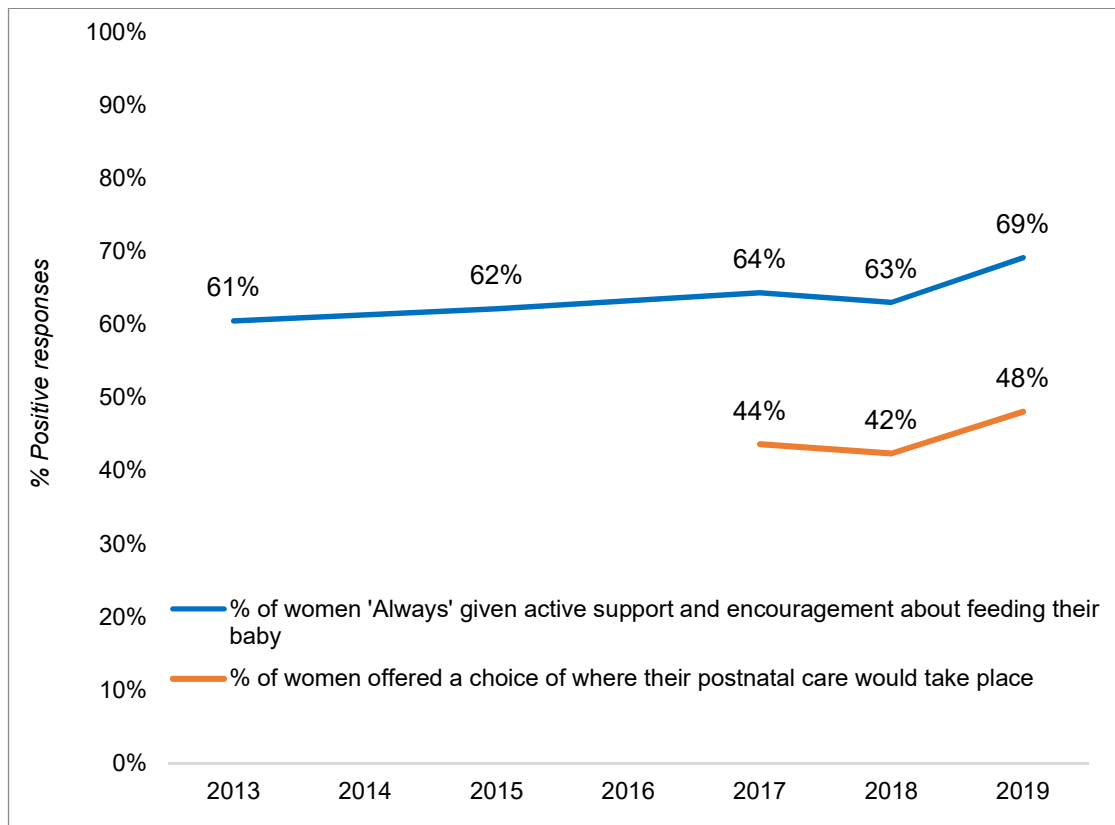


43. The area of maternity care in which women express the lowest confidence is postnatal care. This has been the case for some time, but some significant improvements are now being seen. This is expected to improve further as work to improve postnatal care continues (as described in paragraph 75).

- 74% of women responded that their partner or someone else close to them could stay with them in hospital after birth as much as they wanted. This was up by 2.9 percentage points since 2018 (71%).
- 85% of women felt that their decisions about how they wanted to feed their baby were always respected by their midwives. up by 2.2 percentage point since 2018 (83%).
- 69% of women responded that they were given active support and encouragement about feeding their baby, up by 6.1 percentage points since 2018 (63%). 48% of women responded that they were given a choice about

where their postnatal care would take place, up by 5.7 percentage points since 2018 (42%).

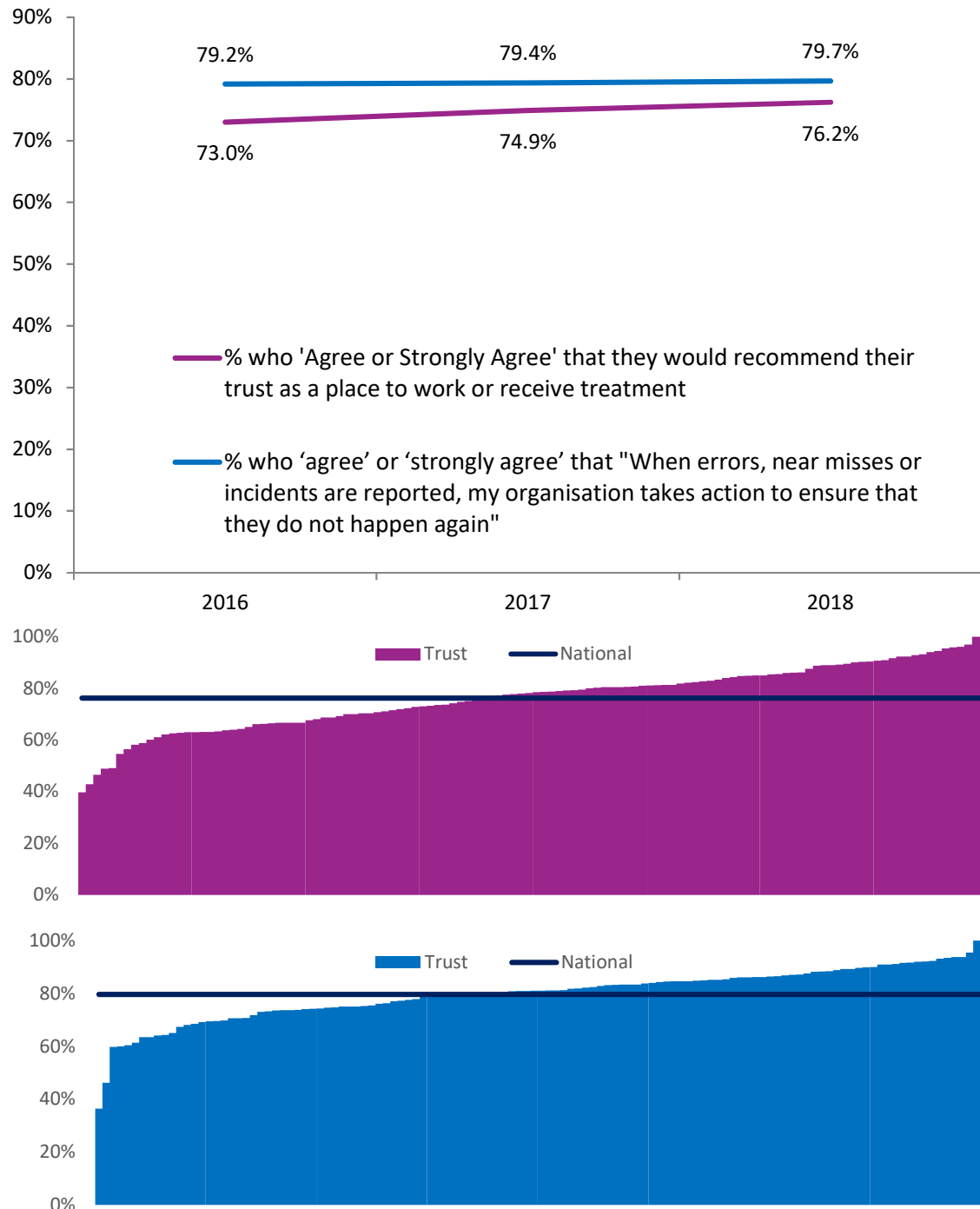
Figure 17. There were significant recent improvements in women feeling supported and encouraged about feeding their baby and women being offered a choice of where their postnatal care would take place. However, there is significant scope for further progress. (Data source: [2019 CQC Maternity Survey](#))



Our staff: what is our workforce telling us?

44. National Maternity Indicators relating to organisational culture show some improvement in the reported experience of midwives regarding their view of their own organisation. Feedback on the learning culture has remained relatively stable with eight out of ten midwives feeling that their organisation takes action to ensure errors and near misses do not happen again. However, there is notable variation at trust level in results for both questions regarding midwives' experience of their organisation's culture.

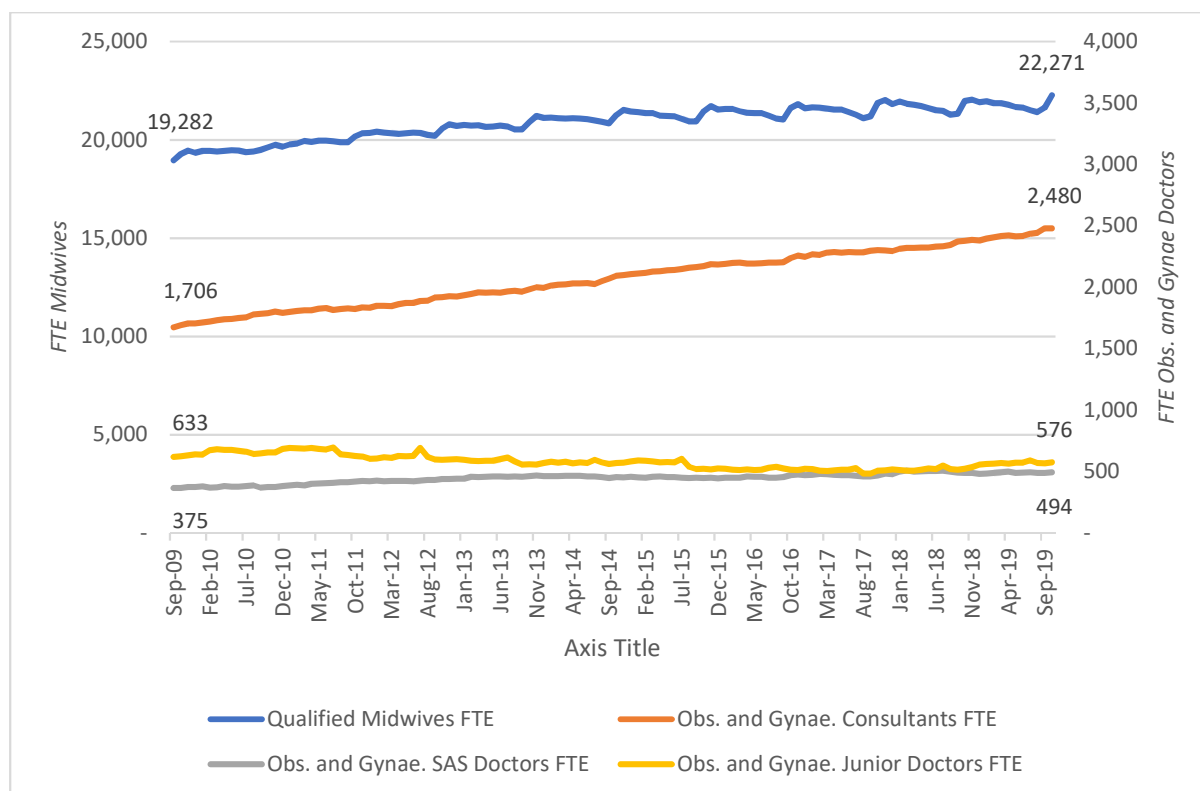
Figure 18. The majority of midwives would recommend their trust as a place to work or receive treatment. While there have been improvements in midwives reported experience of learning culture within their organisations in recent years there is notable variation at trust level and scope for further improvement. (Data source: Analysis of [NHS Staff Surveys 2016 to 2018](#), trust variation charts are based on 2018 data)



Our staff: workforce numbers

45. The last ten years has seen a 15.5% increase in the numbers of Full Time Equivalent (FTE) midwives from 19,282 in October 2009 to 22,271 in October 2019. The number of FTE Consultants and SAS Doctors¹³ in the Obstetrics and Gynaecology Specialty Group has risen by 46.7% and 34.7% respectively over the same time period, however there has been a 7.7% reduction in the number of Junior doctors working in the specialty group from 633 to 576.

Figure 19. There have been increases in numbers of midwives and senior doctors working in Obstetrics and Gynaecology over the last ten years, however, junior doctor numbers have fallen. (Data source: [NHS Digital Workforce Statistics October 2019](#))



New models of care

46. **Better Births** called for new ways of providing care to help make it safer and more personalised.

47. **Continuity of carer** means that women receive care from the same midwife or small team of midwives throughout antenatal care, labour and birth, and the postnatal period. NHS England and NHS Improvement has an ambition for most

¹³ Specialty doctors, associate specialist doctors and staff grade doctors

women to be receiving this type of care by March 2021. Continuity of carer pathways have now been implemented across nearly all provider trusts. In March 2019, 17.3% of women (10,535) were placed on a continuity of carer pathway. The next milestone is end March 2020, when we have a national ambition for 35% of women to be placed on a continuity of carer pathway.

48. *Better Births* called for investment in electronic, interoperable maternity records to reduce the administrative burden of information recording and sharing, and comprehensive digital sources of information for all women, which are personalised and accessible via a digital tool or “**Maternity Digital Care Record**”. The *NHS Long Term Plan* commits to offering 100,000 women access to their maternity digital care records by March 2020, expanding to all women by March 2024. Good progress has been made. 20 pilot sites have been established and we passed the 100,000 target in September 2019, eight months ahead of plan. By December 129,102 women had been offered access.
49. **Perinatal mental illness** affects up to 20% of new and expectant mothers and covers a wide range of conditions, such as anxiety, depression and or postpartum psychosis. Suicide is a leading cause of maternal death in the UK up to one year post-partum according to reports by MBRRACE-UK (most recent information 2015-17). Untreated perinatal mental illness has been estimated to cost the NHS and social services around £1.2 billion for each annual cohort of births.¹⁴ A significant proportion of this relates to adverse impact on the child. Both the *Five Year Forward View for Mental Health* and the *NHS Long Term Plan* set strong ambitions to improve access to specialist perinatal mental health services for women in all areas of England, both inpatient Mother and Baby Units (MBUs) and in the community, backed by significant financial investment (more than £900m from 19/20-23/24).
50. Five years ago, 40% of the country had no access to specialist perinatal mental health care. Since March 2019, there has been a specialist perinatal mental health community service in every Sustainability and Transformation Partnership (STP) area of England. 700 new specialist staff were recruited to community services between 2017 and 2019 and over 13,000 additional women seen in 2018/19 (exceeding the ambition of 9,000). There are four new Mother and Baby Units opened in areas of particular need (North West, South West, South East Coast and East of England), with overall capacity to increase by 49% by March 2021.
51. Many Local Maternity Systems are investing in **community hubs**, which bring a range of antenatal, postnatal and sometimes intrapartum care services together in one setting closer to women’s homes. Data on the number of community hubs

¹⁴ LSE and Centre for Mental Health, 2014

is not routinely collected, but the Maternity Transformation Programme team has identified more than 100 that had opened by December 2019.

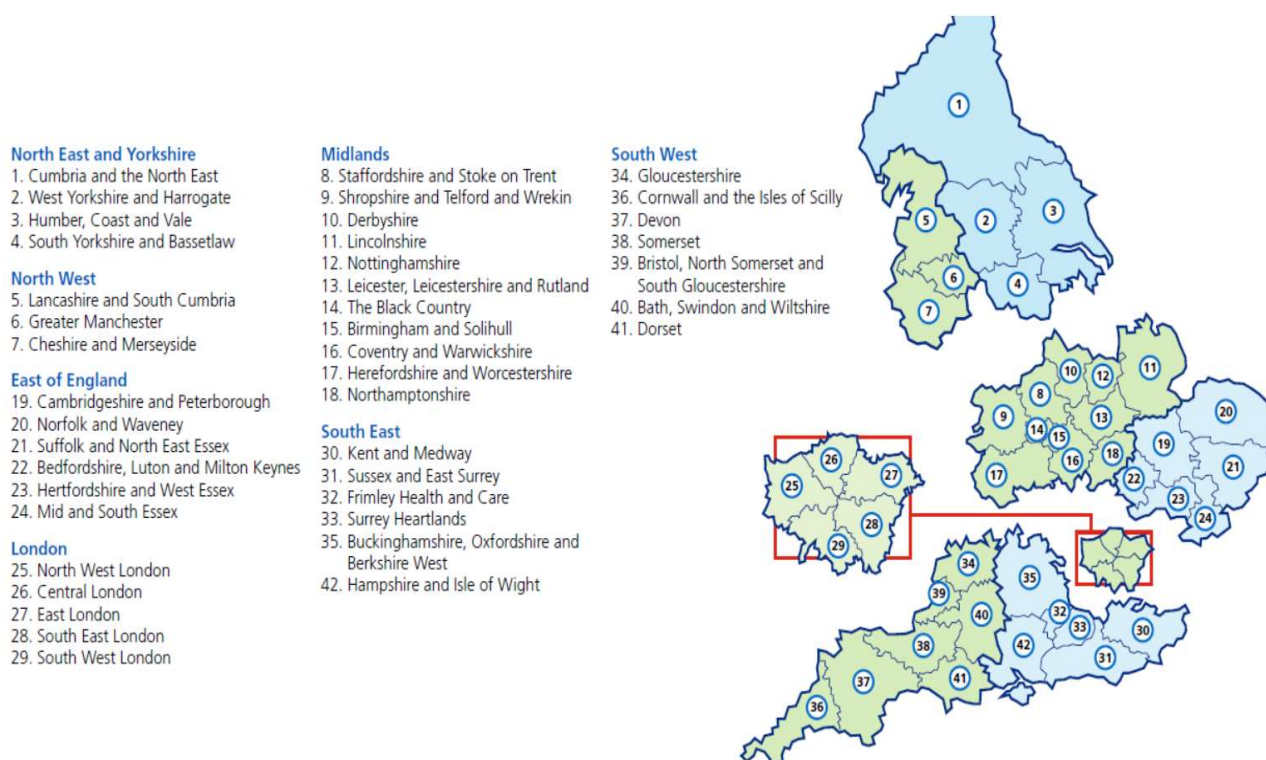
Summary

52. In summary, the data shows that good progress is being made over time in reducing perinatal and maternal mortality, despite an overall increase in the complexity of care. More needs to be done to understand the position with regard to brain injuries, and more needs to be done both to tackle pre-term birth and support pregnant women who smoke to give up, because these trajectories are not on track to meet the national ambition, and to reduce inequalities.
53. Looking into the other clinical indicators which are available is also illuminating. This highlights an increased willingness on the part of women and their clinicians to use medical interventions, such as induction and caesarean section. At the same time, the CQC survey results show that women are more likely to feel listened to when they raise a concern during labour, and midwives are more likely to report faith in the quality of the care they are providing. However, attention needs to be given to understanding whether care is configured so as to minimise other complications of childbirth, such as third or fourth degree perineal tears and postpartum haemorrhage.
54. At the same time there is a degree of variation between different provider trusts. Although this is not as significant as originally appears for perinatal mortality once clinical risk, demographics and natural statistical variation is taken into account, there remains a need to investigate and understand this variation at local and national levels, to ensure that improvements to maternity care are being made universally.
55. The next section of this report explains what has been done already to improve maternity care and what further action is planned to go further faster.

What are we doing to improve quality and outcomes?

56. The Maternity Transformation Programme has been in place since 2016 to implement the vision set out in *Better Births* for safer and more personalised care, alongside the Department of Health and Social Care's *Safer Maternity Care* action plan.¹⁵ Ultimately all of its activity aims to support local service users, commissioners and providers coming together as Local Maternity Systems (LMSs) to deliver transformation on the ground.

Figure 20. Local Maternity Systems and NHS Regions geographic footprints



57. Nationally, the Maternity Transformation Programme Board determines a consistent set of expectations for all LMSs, supported by a number of initiatives to guide LMSs on the best way to improve services. It brings various organisations together in partnership, including NHS England and NHS Improvement, the Care Quality Commission, Health Education England, HSIB, NHS Resolution, the Department of Health and Social Care, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

58. The programme has two core themes which run throughout all of its activities: providing safer care, and providing more personalised care to women. Workstreams are taken forward to ensure that these twin aims are met, and that

¹⁵ <https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps>

all actions seek to address both. Over the last four years it has become increasingly clear that actions to deliver more personalised care will also have a significant impact on making care safer. This interdependency is important and one which the programme seeks to demonstrate and emphasise through all of its activities.

Making care safer

59. The Maternity Transformation Programme uses the PIER framework to shape its interventions to improve safety:

- Prevention
- Identification
- Escalation
- Response

60. This report therefore also uses this framework to explain progress with rollout.

Prevention

61. In order to drive improvement in outcomes, the Maternity Transformation Programme has put a number of initiatives in place, by seeking to identify best practice and promoting universal implementation. The first group of initiatives involves action targeted at changes to clinical practice and service models:

- The **Saving Babies' Lives Care Bundle**¹⁶ helps to reduce stillbirths and neonatal deaths by improving management of four issues where there is a link to these outcomes:
 - smoking in pregnancy;
 - detecting fetal growth restriction;
 - raising awareness of reduced fetal movement; and
 - improving effective fetal monitoring in labour.

A fifth element on reducing pre-term birth will directly impact on the number of pre-term births, but, given that preterm birth carries a higher risk of perinatal mortality and intrapartum brain injury, it will also help reduce these types of outcome.

- The **Atain programme**¹⁷ helps to reduce avoidable admission of full term babies to a neonatal unit. It focuses on four key areas (hypoglycaemia,

¹⁶ <https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/>

¹⁷ <https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/>

jaundice, respiratory conditions and asphyxia (hypoxic–ischaemic encephalopathy)) so that avoidable harm is reduced, separation of mother and baby is minimised and that any additional neonatal care required is provided by keeping mothers and babies together where safe to do so.

- **Continuity of carer** is currently being rolled out to most women. Women who receive continuity of carer are 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.
- We are improving access to **specialist perinatal mental health services**. As set out in paragraph 50 above, there has been a major expansion of services, underpinned by significant investment. This will help reduce maternal mortality given that suicide is the biggest cause between six weeks and a year after birth.
- We are taking action to increase the proportion of women at less than 27 weeks' gestation who are giving birth in a hospital with appropriate on site **neonatal** care. This will help to reduce intrapartum brain injuries and neonatal mortality as it will ensure women and their babies get expert obstetric and neonatal care.

62. In addition, further action targeted at change to clinical practice and service models is in the planning stage:

- **Continuity of carer** will be rolled out to 75% of **women with a Black, Asian and minority ethnic (BAME) background** and from the **most deprived areas** by 2024 on the principle of proportionate universalism, so as to reduce inequalities in stillbirth and preterm birth rates.
- The *NHS Long Term Plan* sets out a number of commitments to improve access to and the quality of perinatal mental health services. These include **maternity outreach clinics**, which will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.
- **Networked maternal medicine** will enable every woman in England with acute and chronic medical problems to have timely access to specialist preconceptual advice and care during and after pregnancy from 2021/22. This will directly tackle maternal mortality, but is also likely to have an impact on perinatal mortality and intrapartum brain injuries.

- In line with the NHS Long Term Plan commitments, from 2021/22 we will invest in **neonatal services**, implementing the findings of the new Neonatal Critical Care Review¹⁸ by end 2023/24, including: extra capacity in neonatal nurse and allied health professional staffing, and in extra cots in parts of England where required.
- Rolling out a new NHS model for **supporting pregnant women who smoke to give up** from 2020/21. This will help reduce perinatal mortality and preterm birth.
- Rolling out **Continuous Glucose Monitoring (CGM)** for women with type 1 diabetes from 2020/21. This will improve outcomes in neonatal care.

63. The second group of initiatives will have an impact across the board by helping to create a culture which listens to women, values learning and builds multi-professional team working through a common vision for safety:

- **Learning from adverse events** through reports which summarise good practice and where action needs to be taken. These include Each Baby Counts,¹⁹ MBRRACE-UK's confidential Enquiries and surveillance audits,²⁰ the Perinatal Mortality Review Tool²¹ (which all provider trusts now use to review stillbirths and neonatal deaths), NHS Resolution's Early Notification Scheme²² and investigations by HSIB.
- Improved data sources through version two of the **Maternity Services Dataset**. This contains a much richer source of data on clinical quality and a data viewer makes it easier for units to access data and make comparisons.
- Appointing **safety champions** at board and at the frontline in maternity and neonatal services, as well as regionally and nationally, whose job it is to promote a safety culture and ensure there is sufficient attention given to safety and culture at all levels.
- The **Maternity Safety Training Fund**, which provided £8.1m of funding for multi-professional safety training across England in early 2018.

¹⁸ <https://www.england.nhs.uk/publication/implementing-the-recommendations-of-the-neonatal-critical-care-transformation-review/>

¹⁹ <https://www.rcog.org.uk/eachbabycounts>

²⁰ <https://www.npeu.ox.ac.uk/mbrpace-uk>

²¹ <https://www.npeu.ox.ac.uk/pmrt>

²² <https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/>

- Empowering women to get involved and co-produce developments in local services through **Maternity Voices Partnerships**.
- A staff-focussed **communications** campaign, with “personal and safe” as its key message, supported by “how to” guides helping people at all points in the system to understand their role.

64. In addition, the **Maternity and Neonatal Safety Improvement Programme**²³ (MatNeoSIP) is using quality improvement methodology with all maternity and neonatal provider trusts to reduce unwarranted variation in care, improve the quality and experience of care for women, and improve clinical outcomes in five national clinical drivers. The programme brings together local organisations to work collaboratively with system partners, build improvement capability, spread improvement, and learn from areas of clinical excellence. All Maternity and neonatal provider organisations have nominated leads trained in quality improvement methodology, developed a local improvement plan, assessed their safety culture and are continuing to be supported to deliver their local and system wide improvement plans.

65. From April 2020, the MatNeoSIP will enter a new phase. It will build on learning from the last three years of the programme in terms of what makes changes happen, and its curricula will evolve according to the latest learning from e.g., HSIB, the Perinatal Mortality Review Tool, the Early Notification Scheme and Care Quality Commission inspections. It will therefore be the primary approach to help trusts universally turn themes emerging from learning nationally into changes to clinical practice, behaviour and service models locally.

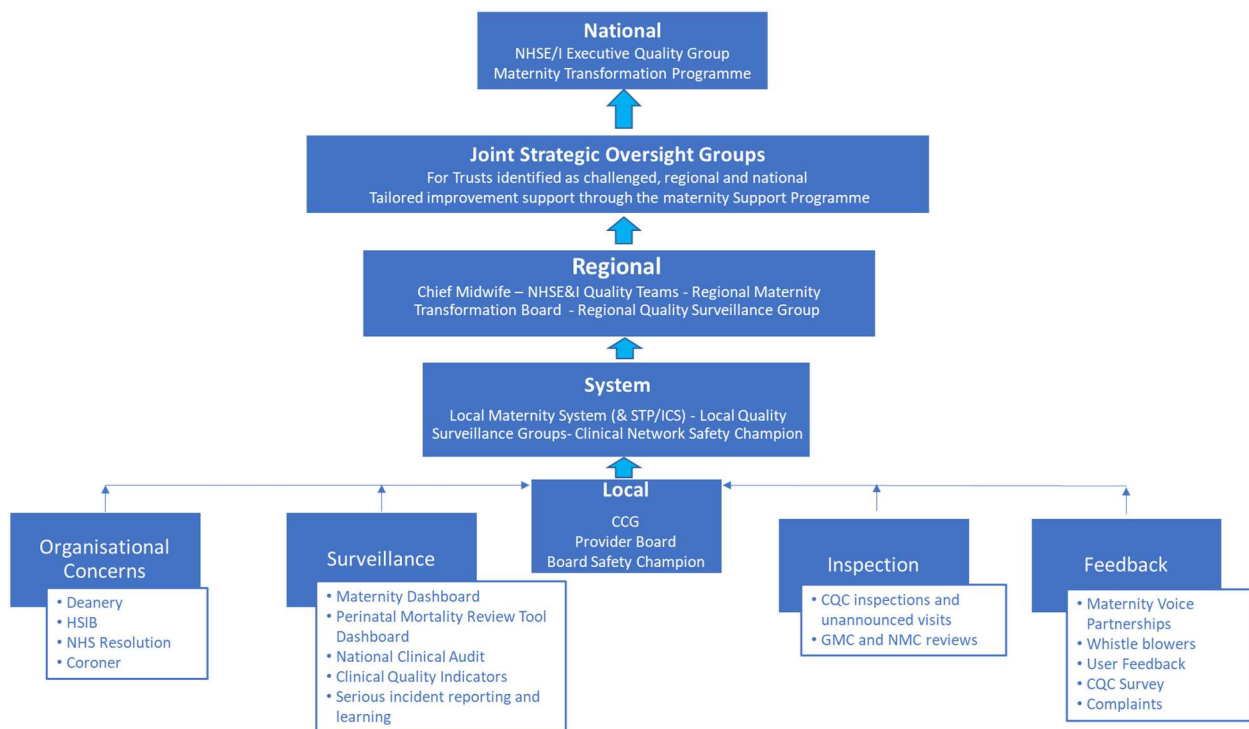
Identification and escalation

66. Various processes are in place in NHS organisations and amongst partners such as the CQC, HSIB, NHS Resolution and the Royal Colleges, to identify and escalate concerns about the quality of care in individual trusts. While some sources of information and process are unique to the maternity setting, services are also subject to the routine quality surveillance mechanisms which apply across the NHS to all services: locally through board level oversight (which in maternity is supported by board safety champions), at system level (which in maternity is through LMS challenge and 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.

²³ <https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/>

67. To supplement this existing system and ensure that it can best use the information and intelligence at its disposal, NHS England and NHS Improvement is developing of a new dedicated maternity module which will operate through the quality surveillance and governance structures to enable the identification and escalation of concerns. This will involve a continuous rolling 360° maternity safety assessment. Given that outcomes data alone does not provide sufficient indication of quality of care there is a need to get beyond normal statistical variation and into a more sophisticated understanding of what is happening in an individual trust. This means triangulating quantitative and qualitative and information from a variety of sources. Much of the information taken into consideration will reflect outcomes and events within the previous three months. The detail is still in development, but an outline of the approach is set out in figure 21.

Figure 21. Maternity surveillance, escalation and governance



Response

68. NHS England and NHS Improvement’s current highest level of maternity-specific response involves placing trusts on the Maternity Safety Support Programme. This involves senior clinical leads providing hands on support to provider trusts, through visits, mentoring, and leadership development. Its original inclusion criteria were:

- maternity services which have an overall rating of inadequate by the CQC;
- 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
- maternity services issued with a CQC warning notice.

69. It has been successful in helping provider trusts to improve, with nearly all improving their CQC inspection ratings, and leaving the programme in a much better position than when they started. However, there has continued to be a number of cases in a small number of providers where care has fallen well short of the standard that is expected, leading to NHS England and NHS Improvement commissioning independent reviews, such as Donna Ockenden's review of care at Shrewsbury and Telford Hospital NHS Trust and Dr Bill Kirkup's review of care at East Kent Hospitals University NHS Foundation Trust. The learning from these reviews will be vital in ensuring that the right action can be taken to improve services in these areas and nationally.

70. NHS England and NHS Improvement is therefore expanding the eligibility criteria to include a number of other triggers, including provider trusts identified through the identification and escalation process outlined previously. Alongside this, exit criteria are being strengthened and new governance is being put in place.

71. In addition, NHS England and NHS Improvement is dedicating additional resources to this programme, including dedicated obstetric input, as well as national and regional resources. NHS England and NHS Improvement has already strengthened its regional midwifery leadership and the seven regional chief midwifery officers will lead the programme in each region.

Making care more personalised

72. The *Better Births* vision is for personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information and supported by digital tools.

73. The *NHS Long Term Plan* further reinforced the importance of personalised care, stating that it should become 'business as usual' across the health and care system. An action plan – *Universal Personalised Care: Implementing the Comprehensive Model*²⁴ – has been developed to outline how personalised care will be rolled out nationally across all clinical areas by March 2024.

74. A growing body of 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. Personalised care also has a positive impact on health inequalities, taking account of people's different backgrounds and preferences, with people from lower socio-economic groups able to benefit the most from personalised care. Therefore, personalisation, based on a robust and continued assessment of an individual's circumstances and choices and, based on a

²⁴ <https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/>

relationship of trust between the woman and her clinicians, is a prerequisite for the safest care.

75. In order to promote greater personalisation of maternity care, the Maternity Transformation Programme has put a number of initiatives in place, by seeking to identify best practice and promoting universal implementation:

- **Continuity of carer** has been included in the section on making care safer because the evidence shows a link between continuity of carer and improved outcomes. It is also fundamentally important to personalisation as it enables a woman to build a longer term relationship of mutual trust and respect with her midwife, who can support her to make informed decisions. By March 2021, our ambition is for the majority of woman to be receiving this model of care.
- Local Maternity Systems have been asked to make sure that all women are able to draw up their own **Personalised Care and Support Plan**, underpinned by support from their midwife, including an open, but tailored conversation about the choices available. This should be owned by the woman, record her choices and provide a summary of conversations she has had with her midwife about her choices. It remains a live document throughout pregnancy, labour and childbirth and the postnatal period, and must be reviewed on every contact to ensure that it reflects the latest information about the woman's care needs, as well as enabling her to change her decisions at any point. To help with decisions during labour, which sometimes need to be made quickly, NHS England and NHS Improvement is working with partners to develop a decision-making tool.
- To support personalised care and support planning, the Maternity Transformation Programme is encouraging the use personalised digital communication through the rollout of **Maternity Digital Care Records**. Maternity Digital Care Records will not only be able the women to share their Personalised Care and Support Plan with their clinicians, but it will also enable all women to access the information they need which is most relevant to them based on their individual circumstances. All women will have access to their Maternity Digital Care Record by March 2024.
- Local Maternity Systems have been asked to ensure that women are able to make **choices about their care**. This means making sure that a range of options are available. Choice of place of birth is important and Local Maternity Systems have specifically been asked to improve access to birth in midwifery settings (at home or in midwifery units) for those who want it, given the obvious discrepancy identified in *Better Births* between the number

women who say they want a birth in a midwifery setting and the number of women who achieve this. However, it also means choices about the kind of care women receive, such as type of birth or infant feeding support.

- **Community hubs** provide co-ordinated care services built around the needs of a specific local population, which may include prevention pathways, such as smoking cessation services, and other services working in partnership with local authorities. In some areas this has helped improve access to care. In Lincolnshire, for example, hubs have been opened in children's centres in towns like Skegness and Mablethorpe, from which women have previously had to travel to the nearest hospital for all maternity care. A small number of community hubs are trialling open on demand birthing rooms to increase availability of midwifery birth settings.
- *Better Births* called for improvements to **postnatal care**, and the results of the CQC survey of women using maternity services shows that there remains less confidence in these services. The challenge is that good postnatal care needs to be personalised because the needs of individual women vary substantially. Local Maternity Systems have therefore been asked to develop local improvement plans for postnatal care focusing on:
 - how women will receive personalised and kind care in the postnatal period;
 - effective transfer of care and quality information when returning home;
 - support in the return to physical health after birth;
 - support with infant feeding, including a tailored feeding strategy across the Local Maternity System;
 - improved screening and access to emotional and mental health support, including for bereavement and neonatal care; and
 - effective handover from midwifery to health visiting services and general practice – such as through closer working between midwifery and health visiting.
- Good postnatal care will be supported by the new **check in general practice for each woman six to eight weeks after the birth of her baby**. It will be in addition to the check already offered for the baby and will focus on:
 - a review of the mother's mental health and general wellbeing, using open questioning;
 - the return to physical health following childbirth, and early identification of pelvic health issues;
 - family planning and contraception options; and
 - any conditions that existed before or arise during pregnancy that require on-going management, such as gestational diabetes.

- A key element of improved postnatal care will be better access to **postnatal physiotherapy**, through multidisciplinary pelvic health clinics and pathways, supported by investment identified in the *NHS Long Term Plan*. These clinics will provide care for all women with common issues including incontinence, retention issues, prolapse, back pain and dyspareunia. Rollout will begin with pilot sites later in 2020-21.

Summary

76. In summary, the Maternity Transformation Programme has generated a significant amount of activity since *Better Births* and the *Report of the Morecambe Bay Investigation*. It has shown considerable progress with the implementation of key programme goals, with more work underway.
77. Improvement in safety is built around the PIER framework (prevention, identification, escalation and response). The “prevention” element in particular has delivered a large number of national initiatives focusing on changes to clinical practice and service models, and has more at the planning stage, as well as activities to promote the development of a safety culture in provider trusts. The “identification” and “escalation” elements are being strengthened by the addition of a maternity-specific lens through which to review quality. The Maternity Safety Support Programme, which forms the “response” element, has a track record of helping provider trusts to improve the quality of their care.
78. Improvement in personalisation is built around a number of tools and processes to support and empower women to make decisions about their care, including continuity of carer and personalised care and support planning. There is a particular focus on postnatal care, reflecting less positive feedback provided by women about this element of the service.

Conclusion

79. The data identified in this report highlight some positive improvements in maternity care. In particular there has been a steady reduction in stillbirths, combined perinatal mortality and maternal mortality over time. There has also been a steady improvement over time in what women say about their care. Some other clinical indicators, for example the rate of inductions and the rate of caesarean sections, suggest that these improvements in outcomes are being achieved in the context of greater medical intervention, although, crucially, the improvement in service user satisfaction suggests this is happening with the support of women.
80. Nevertheless, the picture is complex and in some areas more clarity is needed, either because the data source is not yet reliable, as is the case with brain injuries, or because time lags mean it is always out of date. This does not mean that the NHS should avoid tackling the quality of care in areas where the data is poor; rather it should act and wait for the data to catch up. The lag does however mean that the impact of many of the initiatives implemented to improve care as part of the Maternity Transformation Programme is yet to be felt on the outcome data.
81. The data also shows some areas where progress needs to accelerate to deliver the programme's aims. The data have enabled NHS England and NHS Improvement to identify gaps in the programme and put together new initiatives which are already underway or in the planning stage (many of which were identified in the *NHS Long Term Plan*), for example:
- A new element in the Saving Babies' Lives care bundle is aimed specifically at pre-term birth.
 - A new NHS model to help pregnant women to give up smoking will have a direct impact on the number of maternal smokers.
 - Targeting continuity of carer at BAME women and women from deprived areas is aimed at reducing inequalities.
 - Work to improve postnatal care is in response to feedback from women that they have less confidence in this element of the service.
82. The data shows that there remains some variation at local level. Whilst pregnancy and childbirth have in general never been safer, there is understandable public concern about the quality of care in individual units and the NHS has a duty to ensure that the improvements being made available to women, their babies and their families are truly universal.

83. This means that improvements underway to identify individual provider trusts in need of support are likely to be crucial to the success of the programme, alongside strengthening the Maternity Safety Support Programme so that individual trusts have the support they need to make the *Better Births* vision a reality on the ground.
84. It also means that that the Maternity Transformation Programme needs a simple mechanism to ensure that themes emerging from learning nationally on safety are turned universally into changes to clinical practice, behaviour and service models locally. The refreshed Maternity and Neonatal Safety Improvement Programme will take this role going forward. Using this as the primary vehicle for making change happen will also reduce confusion and complexity caused by too many national safety initiatives operating at the same time.
85. Finally, the programme relies on Local Maternity Systems, as the main agents for change, to ensure that they are delivering the evidence-based improvements to care identified by the programme as consistently and quickly as possible. At the same time, they will need a relentless focus on quality, so that transformation and quality go hand in hand.