In February 2016, the National Maternity Review published ‘Better Births’
Review findings: It has never been safer to have a baby…

The stillbirths and neonatal death rate has decreased by 13% since 2010

Under 18 conception rates have almost halved between 1998-2013
Review findings: …But things go wrong too often

- In 2014/15, maternity-related litigation cost the NHS over £500m
  (CQC, Maternity services survey 2015: statistical release)
Review findings: Women don’t always get the choices they want

CQC Survey 2015: During your pregnancy were you given a choice about where your antenatal check-ups would take place?

- Yes: 16%
- No: 84%

10% of women surveyed by NFWI would prefer a home birth.
6% of women surveyed by NFWI preferred to give birth in an FMU.
49% of women surveyed by NFWI would prefer to give birth in an AMU.

Only 25% of women would choose to give birth in an OU.
Support Overdue: Women’s experiences of maternity services

2017
Key findings

• 50% of women experienced clinically unsafe care (red flag event – NICE) during labour
• 88% of women had not met the midwife who cared for her during labour and birth
• 9% of women said all 4 birthplace choices were not available
• 1 in 5 women were not able to see a midwife as required postnatally
• Use of digital technology had positive impact on users both experientially and clinically
Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly.
The Maternity Transformation Programme seeks to implement the various recommendations of Better Births nationwide by 2020/2021, with a consistent focus on:

- Improved choice and personalisation of maternity services.
- Improved safety of maternity care.
MTP: Programme Board brings together all national partners

FYFV CEOs Board

Maternity Transformation Programme Board
Independent Chair: Sarah-Jane Marsh

Maternity CCGIAF Assessment Panel
Chair: Baroness Cumberlege

NHS Improvement
NHS England
Care Quality Commission
Public Health England
Health Education England
NICE

Local Transform’n Workstream
Promoting Safer Care Workstream
Choice and Personalis’n Workstream
Perinatal Mental Health Workstream
Workforce Transform’n Workstream
Data and information Workstream
Technology Workstream
Payment Workstream
Prevention Workstream

Five Year Forward View
The Maternity Transformation Programme: Delivering the vision through 9 work streams

- Driving local change
- Service improvements
- System enablers

Details of the work streams:

- Increasing choice and personalisation
- Supporting local transformation
- Improving access to perinatal mental health services
- Improving prevention
- Transforming the workforce
- Sharing data and information
- Harnessing digital technology
- Reforming the payment system
- Promoting good practice for safer care

Five Year Forward View
By March 2017, Local Maternity Systems (LMS) will be established nationwide, coterminous with STP footprints.
What do we expect Local Maternity Systems to do?

• **By October 2017**, all LMSs will develop a shared vision and plan to implement Better Births in their area by 2020/21. Plans will centre around the delivery of:

  - Improved choice and personalisation of maternity services.
  - Improved safety of maternity care.
Maternity clinical network

Organising specialist services | Sharing best practice and benchmarking network
Improving choice and personalisation: Choice Pioneers

36 CCGs – 17% coverage
Going further, faster with Early Adopters

29 CCGs, 29 providers

North Central London
4 providers
5 CCGs

North West London
4 Providers
8 CCGs

Cheshire & Merseyside STP
10 providers, including x2 independent
8 CCGs.

BUMP – Birmingham & Solihull
STP 3 CCG’s 3 providers
3 CCGs

Somerset STP
2 providers
1 CCG

Surrey Heartlands
3 providers 3 CCGs

Dorset STP
3 providers 1 CCG
SERVICES COULD INCLUDE:

- Diagnostics
- Obstetric services in the community
- Community midwives
- Home birth team
- GP support
- Social services
- Midwifery practices

HOSPITAL

COMMUNITY HUB
Located in e.g. children's centre, GP practice, midwife-led unit
Maternity Transformation: Delivered locally, enabled locally

LOCAL TRANSFORMATION ....

- Local Maternity Systems
- Investigating and learning when things go wrong
- Community Hubs
- Continuity of carer
- Shared clinical governance, protocols and data
- Leadership for change
- Digital records and info sharing
- Multi-disciplinary team working & training

.... ENABLED NATIONALLY

- Pricing and payment reform; local variations
- Digital infrastructure
- Guidance and resources
- Selecting & supporting early adopters
- National indicator set and dashboard
- National quality improvement programme
- Providing funding to enable change
- Workforce analysis and supply

Five Year Forward View 19
Improving safety: Rapid resolution and redress

Data from Sweden showing the frequency per 100,000 born of settled claims involving serious birth injuries per year 2000-2015.

- Department of Health Consultation now live – closes 26 May.
- Search for ‘Rapid Resolution Redress consultation’ to participate.
A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury: a Consultation

2nd March to 26th May
RRR: A two stage process to ensure lessons and learnt and families get the support they need as quickly as possible.
Rapid Resolution and Redress (RRR): Consultation Points and Suggestions

• Should include Still Births (circa 102 cases) and Early Neonatal Deaths (circa 125 cases) in addition to the 559 estimated cases of Severe Birth Injury in babies of 37 weeks gestation (2500g)

• Investigations for avoidable harm to be carried out by a trained investigator rather than a panel. It would work with Families and Clinical staff on a “no blame” basis, as in other risk critical industries, and with the Each Bay Counts initiative.

• A new RRR body should be set up associated with but independent from the NHSLA and lead by an Ombudsman. It would also link to the new Health Safety Investigation Branch.

• This body (?Maternity Investigation Branch) would be responsible for determining avoidable harm and recommending settlement to the NHSLA.

• At any time Families could pursue a claim through the Tort system

Cyril Chantler March 2017
Improving safety: Work towards the Secretary of State’s ‘Halve it’ ambition

Ambition:
By 2030, reduce the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth in England by 50%, with 20% by 2020.
The CCG IAF will provide intelligence and a lever for change

**what are we measuring?**

- Stillbirth and neonatal mortality rate (ONS)
- Maternal smoking at time of delivery (SATOD)
- Women’s experience of maternity services (CQC Survey 2015)
- Women’s choice in maternity services (CQC Survey 2015)

**Using the CCG IAF in the context of the MTP**

Although designed to assess CCGs, the Framework indicators will help us gauge how effective LMS are in commissioning and delivering services, and target support to improve

**Indicator profiles of CCGs with the greatest scope for improvement:**

- Scope for greatest improvement against indicators: 11
- Scope for significant improvement against key indicators: 144
- Performing well against key indicators with scope for improvement: 53
- Leading performance against key indicators: 1
Stay connected

• Follow us on Twitter and use our programme hashtags: @NHSEngland, #MatImp #MatExp

• Keep up to date through our web site england.nhs.uk/ourwork/futurenhs/mat-transformation/

• Keep in touch england.maternitytransformation@nhs.net

• Keep an eye out for future bulletin updates
Be bold and go for it

- **Local Maternity Systems** are agents for delivering Better Births

- **Don't wait for instruction** - take Better Births and look at how your service can be adapted to deliver the model of care it envisages

- **Early Adopters** will go further faster, but everyone needs to transform.

- **Share your thoughts and ideas** with your peers and your local Maternity Clinical Network. They are there to help you