

Three year delivery plan for maternity and neonatal services

March 2023



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Summary

With this plan we aim to make care safer, more personalised, and more equitable, by:

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide “PSIRF” approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new “MEWS” and “NEWTT-2” tools by 2025.
- In 2023, NHS England’s new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Introduction

1. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. We are grateful to the many people and organisations that have shared what needs to be done including NHS staff, Donna Ockenden, Dr Bill Kirkup, and organisations representing families. Most importantly, we would like to thank those using maternity and neonatal services for informing this plan. While the birth of a baby represents the happiest moment of many people's lives, some families have experienced unacceptable care, trauma, and loss, and with incredible bravery have rightly challenged the NHS to improve.
2. The summary above sets out the benefits we expect to deliver for families through this plan. This will continue to require the dedication of everyone working in NHS maternity and neonatal services in England, who work tirelessly to support families and improve care. Most women have a positive experience of NHS maternity and neonatal services, and outcomes have improved with over 900 more families welcoming a healthy baby each year compared to 2010.
3. But we must acknowledge that there are times when the care we provide is not as good as we want it to be. Recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent, and previously Morecambe Bay, set out many examples of poor care over years. We know that families from some groups, especially ethnic minorities, have had particularly poor experiences. We must work together to change this, and this plan sets out how we will do this.
4. In preparing this plan we have listened to what you have to say. We know all staff want women and babies to be at the centre of care, and with so many improvement initiatives it can be difficult to know what to prioritise. We know gaps in staffing mean those who provide care do not always have time to learn and improve, and on occasion, struggle to provide care to the highest standards. We have heard that some people feel disempowered by negative team cultures and a lack of strong leadership.
5. For the next three years, we are asking services to concentrate on **four high level themes**. Please take some time to consider these themes, what they mean to you and to the women and babies you care for. Working together, we can make a real difference.

Responsibilities

6. This plan sets out what we need to have in place, and responsibilities for each part of the NHS:
 - Trusts are the main operational unit of maternity services in the NHS and the employer of most staff. Trust boards have a statutory duty to ensure the safety of care, including ensuring staff have the resources they need.
 - Integrated care boards (ICBs) commission most maternity services. Each ICB will be a partner in an integrated care system (ICS). ICSs are a partnership of organisations that plan and deliver joined up health and care services. The local maternity and neonatal system (LMNS) is the maternity and neonatal arm of the ICS. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making.
 - NHS England provides national leadership for the NHS in England. NHS England operates through regional teams which are responsible for relationships with individual ICBs. NHS England has statutory responsibility for commissioning neonatal services, through regional specialised commissioning teams and operational delivery networks (ODNs).
7. It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns. We have sought to improve our approach to quality surveillance at trust, ICS, regional, and national level. This involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information. Some trusts need additional support to improve – this is provided through the Maternity Safety Support Programme (MSSP), which aligns with the overall NHS Oversight Framework and tiered support, so that support for maternity and neonatal care forms part of a wider response where needed.

What you told us

8. We could not develop this delivery plan without talking to people who use, work in, lead, or have an interest in these services. We want to thank everyone who shared their views to inform this plan. We held 50 meetings reaching over 1,000 attendees, including 191 service users, 419 workforce members, 329 leaders of services, systems, and regions, and 106 stakeholders. We additionally received 2,128 responses to our survey from 782 service users, 1,133 workforce members, 105 leaders, and 108 stakeholders.
9. While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in this plan also applies to these individuals; particularly the principles described in Theme 1.
10. While each of the groups who helped inform this plan had different areas they gave greatest importance to, there was clear agreement on what the plan's focus should be. This consensus has shaped the four themes, and the objectives within each of these.
11. The most consistent priority among those using and providing services was safe care. Delivering safe care remains central to this delivery plan.

“Safe, compassionate care, which allows you the confidence to speak up and be listened to if something is not right.” (Service user)

“We need to take action and make a pledge to improve the safety of every maternity service in England.” (Leader)
12. You told us how important improving equity and equality is. We have a dedicated objective on improving equity.

“Those that are most vulnerable should be enabled to have a strong voice within maternity care provision.” (Stakeholder)

13. You told us that we need to be clear about who is responsible for doing what, and to bring the asks of services and systems into one place. This delivery plan sets out clear responsibilities and measures of success across services and systems.

“One clear plan that looks to encompass the recommendations from various reports such as Better Births, Ockenden, Kirkup.” (Workforce member)

Listening to and working with women and families with compassion

14. You told us that personalised care supports safety, makes women feel valued, and avoids families needing to re-tell their story – who they are or what they need. You told us it is important to join up care across maternity and neonatal pathways.

“To be treated as an individual human being.” (Service user)

“Consistency! I saw so many different people I had to tell them my 'story' every time.” (Service user)

“Being fully informed without judgement on pros and cons of all care offered.” (Service user)

“Listening to the families using the care and embedding their voices along all pathway.” (Leader)

“Supporting parents to be actively involved in the care of their baby on the neonatal unit (family integrated care).” (Service users)

Growing, retaining, and supporting our workforce

15. You told us that there needs to be enough staff in services, with the time and training to support their effectiveness as well as to protect their wellbeing.

“Safe staffing that will then provide safe and personalised care.” (Leader)

“Enough staffing to feel supported, safe and provide care when it is needed.” (Service user)

“Adequate staff with the appropriate training working in the right environment. Having the time and resources to listen to women and their families.” (Workforce member)

Developing and sustaining a culture of safety, learning, and support

16. You told us that there needs to be a positive culture and leadership in services. Staff need to be free to speak up, in an environment that learns from experiences and incidents and does so with compassion.

“Listening, learning and facing up to failings.” (Stakeholder)

“Confidence in the care provider, trust, integrity and honesty if mistakes occur.”
(Leader)

“Leadership training to enable managers to better manage teams and support them.”
(Workforce member)

“Psychological safety at work and teams that work together with a shared vision and a foundation of kindness.” (Stakeholder)

Standards and structures that underpin safer, more personalised, and more equitable care

17. You told us that we need to improve our data collection to help oversight and improvement, among other important standards and infrastructure. Our fourth theme focuses on these crucial elements that support the other themes.

“Notes to be available to all staff when required rather than just to one person.”
(Service user)

“Delivering high quality, evidence-based care in a local environment for service users.”
(Workforce member)

“Improved data collection and IT systems - joined up maternity and neonatal electronic patient record systems which are user friendly and accessible.” (Workforce member)

“Organisational transparency and providing in depth data to provide meaningful data that can be used to prevent as well as respond to trends and themes.” (Leader)

Theme 1: Listening to and working with women and families with compassion

1.1 Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. [Better Births](#) identified that “women wanted to be listened to about what they want for themselves and their baby, and to be taken seriously when they raise concerns”. The [Ockenden report](#) into maternity services at Shrewsbury and Telford described how families who raised concerns “were brushed aside, ignored and not listened to”. This section sets out actions for personalised care, improving equity, and working with service users.

1.2 Key commitments for women and families include:

Empowering staff to ensure that all women are offered personalised care and support plans as part of their care.

Ensuring pregnant women and new mothers have access to pelvic health services in every area of England by 2024 to identify, prevent, and treat common pelvic floor problems.

Rolling out perinatal mental health services to improve the availability of this specialist care.

Investing to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who sadly experience loss.

Funding to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.

Implementing local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality.

Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Objective 1: Care that is personalised

1.3 Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs. This information can be included in each personalised care and support plan to help ensure that service users do not have to repeat their story. While many women and babies experience excellent personalised care ([CQC](#), 2023), it is clear from independent reports that not all do.

1.4 Our ambition is:

- Women experience care that is always kind and compassionate. They are listened and responded to.
- Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected.
- All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and [Core20PLUS5](#). The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.
- Women receive care that has a [life course approach](#) and preventative perspective, to ensure holistic care for women and [the best start in life for babies](#). This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination.
- Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the [Re:Birth report](#), and is co-produced.
- All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and fetal medicine networks, and neonatal care, when needed.
- Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8

weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies.

- Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.
- Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.

How we will make this happen

1.5 It is the responsibility of trusts to:

- Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.
- Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.
- Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that [NHS England set out](#) in September 2022.
- Achieve the standard of the [UNICEF UK Baby Friendly Initiative \(BFI\)](#) for infant feeding, or an equivalent initiative, by March 2027.

1.6 It is the responsibility of integrated care boards (ICBs) to:

- Commission for and monitor [implementation of personalised care](#) for every woman.
- Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.
- Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care.

1.7 NHS England will:

- Work with service users and other partners to produce standardised information to aid decision-making, focusing on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour, and pain relief.

- Extend the national support offer to the 38 maternity services yet to achieve UNICEF BFI accreditation or an equivalent initiative.
- Publish national postnatal care guidance by the end of 2023, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.
- In Spring 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.
- Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.
- By March 2024, act on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report.
- Invest to ensure availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.

Objective 2: Improve equity for mothers and babies

- 1.8 Significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived ([MBRRACE-UK](#), 2022). Though we know NHS staff want to provide the best care to every woman and baby, a National Institute for Health and Care Research funded study found that “multiple structural and other biases exist in UK maternity care”. ([Knight, M et al](#), 2021).

The NHS approach to improving equity ([Core20PLUS5](#)) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.

- 1.9 Our ambition is:

- To reduce inequalities for all in access, experience, and outcomes.
- Targeted support where health inequalities exist in line with the principles of [proportionate universalism](#).
- Services listen to and work with women from all backgrounds to improve access, plan, and deliver personalised care. Maternity and neonatal voice partnerships

ensure all groups are heard, including those most at risk of experiencing health inequalities.

- The NHS collaborates with local authority services, other public sector organisations, and a wide range of private and voluntary sector organisations ([NHS Constitution](#) Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities ([WHO](#), 2022).

How we will make this happen:

1.10 It is the responsibility of trusts to:

- Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to [interpreter services](#), and adhering to the [Accessible Information Standard](#) in maternity and neonatal settings.
- Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.

1.11 It is the responsibility of ICBs to:

- During 2023/24, continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries.
- Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.

1.12 NHS England will:

- Provide regional and national support for the implementation of LMNS equity and equality action plans.
- Pilot and evaluate new service models designed to reduce inequalities, including enhanced midwifery continuity of carer, and from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas.
- Continue to work with the [Maternity Disparities Taskforce](#) to explore disparities in maternity care and identify how to improve outcomes.

- In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services.

Objective 3: Work with service users to improve care

1.18 Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities ([NICE](#), 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through [maternity and neonatal voices partnerships](#) (MNVPs) and by working with other organisations representing service users.

1.19 Our ambition is:

- MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.
- MNVPs have strategic influence and are embedded in decision-making.
- MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.

1.20 In addition, neonatal parental advisory groups represent service user experience as part of operational delivery networks.

How we will make this happen:

1.21 It is the responsibility of trusts to:

- Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.

1.22 It is the responsibility of ICBs to:

- Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
- Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.
- Ensure service user representatives are members of the local maternity and neonatal system board.

1.23 NHS England will:

- Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.
- Through operational delivery networks, support parent representation in the governance of neonatal services.
- Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement.

Determining success for Theme 1

1.24 We will determine overall success by listening to women and their families:

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) [maternity survey](#). They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation.
- We will use these progress measures:
 - Perinatal pelvic health services and perinatal mental health services are in place.
 - The number of women accessing specialist perinatal mental health services as indicated by the [NHS Mental Health Dashboard](#).
 - The proportion of maternity and neonatal services with [UNICEF BFI accreditation](#).
- Evidence which ICBs can use includes:
 - Feedback on personalised care gathered via MNVPs from a wide range of service users.
 - Local evidence of working with women and families to improve services, including co-production.
- Relevant regulation and incentivisation includes:
 - The [CQC](#) will continue to consider compassionate and personalised care as key lines of enquiry during inspections.
 - The NHS Resolution CNST [Maternity incentive scheme](#) which encourages the use of MNVPs.

Case Study: Seeking Sanctuary Clinic - to enhance the maternity care of anyone seeking sanctuary

The Seeking Sanctuary Clinic, hosted in Berkshire West, is a specialist maternity clinic developed in 2021 from co-production between Royal Berkshire NHS Foundation Trust maternity team, and Berkshire West public health team, to enhance the maternity care of anyone seeking sanctuary such as refugees, asylum seekers, those fleeing conflict, undocumented migrants and people who have been trafficked.

This is a 'one stop shop' style clinic held in a children's centre, delivered in two-hour sessions held every two months, aimed specifically for these families, in addition to their usual antenatal and postnatal care. The barriers to access and inequalities that these families may be experiencing are removed where possible. For example, women are able to bring their partners and children with them, there are interpreters booked for every language in attendance, refreshments are provided and transport is available to support people to get to the clinic.

There are many health care professionals and voluntary organisations that come together at the clinic including midwifery and obstetrics. There is also accessible antenatal education with New Directions, sexual health, health visiting, a tuberculosis service, health in pregnancy advisors, Compass Recovery College (mental health and wellbeing support), Reading Refugee Support and Reading Voluntary Action.

The clinic is ever evolving, and additional professionals and organisations are invited to sessions to meet the bespoke needs of the group. Local charity The Cowshed donated to the clinic enabling each family that attends to be provided a ready-made birth bag to assist them on their journey.

The local Maternity Voices Partnership also attends to offer feedback sessions for these groups. While the project is in an initial evaluation phase, feedback so far has been very positive from service users, with more than fifty families supported so far, predominantly from Afghanistan, Syria, and Ukraine.

Theme 2: Growing, retaining, and supporting our workforce

2.1 The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. We need to change that. The plan is informed by the best available evidence, including the [QMNC framework](#) which underpins the [NMC midwifery standards](#). This theme sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills.

2.2 Key commitments for women and families include:

NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.

Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.

Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.

Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.

Objective 4: Grow our workforce

2.3 The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and

psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements.

2.4 Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.

2.5 Our ambition is for:

- Workforce capacity to grow as quickly as possible to meet local needs.
- Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training, absence, and leave.
- Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning.

How we will make this happen

2.6 It is the responsibility of trusts to:

- Undertake regular local workforce planning, following the principles outlined in [NHS England's workforce planning guidance](#). Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

2.7 It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, [guidelines for the provision of anaesthesia services for an obstetric population](#) and [implementing the recommendations of the neonatal critical care transformation review](#)).

- Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.
- Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and [quality](#) of clinical placements.

2.8 NHS England will:

- Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.
- Boost midwifery workforce supply across undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.
- Increase medical training places across obstetrics and gynaecology and anaesthetics, to expand the consultant workforce in maternity services.
- Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.

Objective 5: Value and retain our workforce

2.9 Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. A growing number of staff who leave are aged under 55 and do so for reasons other than retirement. Some staff groups, including ethnic minority staff, are more likely to report negative experiences of working in NHS maternity and neonatal services. We need to do more to improve the experience of all our staff, to retain them within the NHS.

2.10 Our ambition is:

- Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.
- All staff are included and have equality of opportunity.

- A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.

How we will make this happen

2.11 The [NHS Long Term Plan](#) and [NHS People Plan](#) set out how improving the experience of our NHS people will encourage them to stay with us for longer.

2.12 It is the responsibility of trusts to:

- Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
- Implement equity and equality plan actions to reduce workforce inequalities.
- Create an anti-racist workplace, including for example, acting on the principles set out in the [combatting racial discrimination against minority ethnic nurses, midwives and nursing associates](#) resource.
- Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.
- Offer a [preceptorship programme](#) to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
- Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

2.13 It is the responsibility of ICBs to:

- Share best practice for retention and staff support.
- Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.

2.14 NHS England will:

- Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.
- Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.
- In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.

- In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead.
- Continue to address workforce inequalities through the [Workforce Race Equality Standard](#).
- Provide national guidance for implementation of the [A-Equip model](#) and for the professional midwifery advocate role to provide restorative clinical supervision in local services.
- By July 2023, develop a safe clinical learning environment charter for trusts; by April 2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students. These initiatives will help to ensure high quality clinical placements for those training to be midwives.

Objective 6: Invest in skills

2.15 Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes, yet unwarranted variation in training and competency assessment currently exists, especially for temporary staff (for example, Stulberg et al, 2020, McCulloch et al, 2008).

2.16 Our ambition is:

- All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.
- All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards.
- Training is multi-disciplinary wherever practical to optimise teamworking.

How we will make this happen

2.17 It is the responsibility of trusts to:

- Undertake an annual training needs analysis and make training available to all staff in line with the [core competency framework](#).

- Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with [RCOG guidance](#) and [BAPM guidance](#), respectively.
- Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an [RCOG certificate of eligibility for short-term locums](#).

2.18 NHS England will:

- Refresh the curriculum for maternity support workers (MSWs) by June 2023.
- Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.
- Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development.
- Establish a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks.
- Work with royal colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.
- Through action set out above to grow the workforce, help to address pressures on backfill for training.

Determining success for Theme 2

2.19 We will determine overall success by listening to staff:

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- Our progress measures will be:
 - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
 - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.

- To assess retention, we will continue to monitor staff [turnover](#) and [staff sickness absence rates](#) alongside NHS Staff Survey questions on staff experience and morale.
- Evidence that ICBs can use includes:
 - Progress against workforce, retention, succession, and training plans.
 - Local staff feedback mechanisms.
 - Progress against the [nursing and midwifery high impact retention interventions](#).
- Relevant regulation and incentivisation includes:
 - The CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development.
 - The NHS Resolution CNST maternity incentive scheme incentivises trusts to evidence that training in accordance with the core competency framework is in place.

Case study: One stop obstetric ambulatory service

The Chelsea and Westminster Hospital NHS Foundation Trust cares for approximately 5,500 maternity patients per year. The maternity team identified common themes in complaints about their service, including delays in receiving care and long waits for obstetric or scan reviews. The team felt they could improve triage management, patient experience and care, through a truly multidisciplinary approach so set up a 'one stop' service since January 2021.

The team recognised a key cause of delay within the department was delays in obstetric reviews. They were able to increase consultant presence and recruit a clinical fellow with obstetric ultrasound training to work solely in the triage department for five mornings a week, to deliver a 'see and treat' set up, comparable to the way emergency departments are run.

The triage team also includes midwives and maternity support workers, who greet attendees, perform initial observations and a dedicated receptionist who enables clinicians to focus on care rather than administrative tasks. Some midwives have developed professionally to perform tasks that are usually undertaken by obstetricians, such as prescribing and performing presentation scans.

From October 2022 to February 2023 the service has had on average 850 visits per month, with around 100 ultrasound scans performed. The department answers approximately 2,500 phone calls per month, with one midwife allocated to answer phone calls each day to triage and support women.

Improvements in the new obstetric ambulatory service triage system mean the department works more efficiently and safely with staff feeling better supported. Waiting times have been reduced, with 80-95% of women seen within 15 minutes of arrival which exceeds the national KPI (within 30 minutes) for maternity triage services. Feedback from women has also been increasingly positive. The team are exploring future opportunities to expand the service hours and increase the scope of midwifery and maternity support workers, supporting the team's development and dynamic skillset.

Theme 3: Developing and sustaining a culture of safety, learning, and support

3.1 An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the [Kirkup report](#) stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning. This theme sets out actions in three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

3.2 Key commitments for women and families include:

Supporting staff to work with professionalism, kindness, compassion, and respect. Leaders will empower their teams to do this, with practical guidance and training through the perinatal culture and leadership programme by 2024.

Implementing an NHS-wide approach in 2023 for all incidents to support families with a compassionate response, and to ensure learning.

Listening and acting upon issues raised by staff or service users through Freedom to Speak Up (FTSU) Guardians, the complaints process, or maternity and neonatal voices partnerships (MNVPs).

Objective 7: Develop a positive safety culture

3.3 Culture is everyone's responsibility and key to enabling cultural change is compassionate, diverse, and inclusive leadership in maternity and neonatal services and beyond.

3.4 Our ambition is:

- All staff working in and overseeing maternity and neonatal services:
 - Are supported to work with professionalism, kindness, compassion, and respect.

- Are psychologically safe to voice their thoughts and are open to constructive challenge.
 - Receive constructive appraisals and support with their development.
 - Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
 - There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to ‘how’ things are implemented not just ‘what’.
 - Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.
 - Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.
 - Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.

How we will make this happen

3.5 It is the responsibility of trusts to:

- Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.
- Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.
- At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support [escalation toolkit](#).
- Ensure all staff have access to FTSU [training modules](#) and a Guardian who can support them to speak up when they feel they are unable to in other ways.

3.6 It is the responsibility of ICBs to:

- Monitor the impact of work to improve culture and provide additional support when needed.
- Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.

3.7 NHS England will:

- By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

Objective 8: Learning and improving

3.8 Staff working in maternity and neonatal services have an appreciation and understanding of ‘what good looks like.’ To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and improvement approach, from teams to ICBs.

3.9 Our ambition is framed by the [patient safety incident response framework](#) (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services.

3.10 The [Healthcare Safety Investigation Branch](#) undertake investigations of incidents which meet their criteria. The responsibilities for trusts and ICBs set out below, also apply to these, or any other external investigations.

How we will make this happen

3.11 It is the responsibility of trusts to:

- Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of [duty of candour](#) and a single point of contact for ongoing dialogue with the trust.
- Understand ‘what good looks like’ to meet the needs of their local populations and learn from when things go well and when they do not.
- Respond effectively and openly to patient safety incidents using PSIRF.

- Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.
- Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.
- Consider culture, ethnicity and language when responding to incidents ([NHS England](#), 2021).

3.12 It is the responsibility of ICBs to:

- Share learning and good practice across all trusts in the ICS.
- Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.

3.13 NHS England will:

- Throughout 2023, support the transition to PSIRF through national learning events.
- Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.

Objective 9: Support and oversight

3.14 While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

3.15 Our ambition is:

- Robust oversight through the [perinatal quality surveillance model](#) (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate.
- Well led services, with additional resources channelled to where they are most needed.
- Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.

How we will make this happen

3.16 It is the responsibility of trusts to:

- Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
- Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.
- Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
- Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
- At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the [FTSU guide and improvement tool](#).

3.17 It is the responsibility of ICBs to:

- Commission services that enable safe, equitable, and personalised maternity care for the local population.
- Oversee quality in line with the PQSM and [NQB guidance](#), with maternity and neonatal services included in ICB quality objectives.
- Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.

3.18 NHS England will:

- Through our regional teams, listen to the local NHS and through our national governance listen to frontline staff voices and continue to work RCOG, RCM, BAPM, and others.
- Continue to work closely with national bodies, ICBs, and trusts to address issues escalated to national level.
- Provide nationally consistent support for trusts that need it through the [Maternity Safety Support Programme \(MSSP\)](#).
- Work to align the MSSP with the [NHS oversight framework](#), improve alignment with the recovery support programme, and evaluate the programme by March 2024.
- During 2023/24, test the extent to which the PQSM has been effectively implemented.

- By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.

Determining success for Theme 3

3.19 Achieving meaningful changes in culture will take time and progress measures are difficult to identify and can have unintended consequences. We will primarily determine overall success by listening to the people who use and work in frontline services.

3.20 Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the [NHS Staff Survey](#); the [National Education and Training Survey](#) and the [GMC National Training Survey](#). We will explore how to better understand the experiences of other staff groups.

- The evidence ICBs can use across maternity and neonatal services includes:
 - Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture.
 - Whether trust boards regularly share and act on learning.
 - Staff feedback on how incidents and issues of concern are managed.
- Relevant regulation includes:
 - The CQC will continue to consider whether a trust has a learning and responsive culture, strong leadership, and robust governance.

Case study: NFaST - Neonatal Families and Staff Together, supporting neonatal units to become more emotionally supportive environments

In 2021, the North West Neonatal Operational Delivery Network commissioned Spoons, a Greater Manchester-based charity specialising in neonatal family support, to research how their neonatal units could become more emotionally supportive environments for service users and staff.

The project worked with 13 neonatal units and a 28-family focus group, collecting data from more than 260 parents and 250 staff members, exploring their emotional needs. The project identified that the experience of neonatal care has a profound long-term impact on parents and their infants. In turn, the experience of working on a neonatal unit is emotionally challenging and can have significant impact on a staff member's individual wellbeing.

Volunteer peer supporters, who had personal experience of neonatal care, were trained for the units. Psychological training was provided to 100 staff across four neonatal units, including doctors, nurses, and support staff. Reflective practice group sessions were led by a clinical psychologist, to help the teams collaborate and understand each other and the needs of their babies and families better.

The pool of volunteer peer supporters continues to grow, and additional peer support training has been commissioned, with a model of ongoing supervision in development. This project demonstrates the power of true collaboration between the NHS, service users and third sector partners.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- 4.1 To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow. In many areas this is already in place; this plan does not seek to introduce new standards, extra reporting, or change structures, but to ensure that these enablers are consistently implemented to support care.
- 4.2 Key commitments for women and families include:

Making care safer by consistently implementing best practice, including:

- By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.

In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.

By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.

Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.

Objective 10: Standards to ensure best practice

- 4.3 Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. However, the Ockenden report found that many women cared for at the trust were not offered care in line with best clinical practice. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care. Additionally, the Kirkup report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.
- 4.4 Nationally defined best practice already exists, including:
- The Saving Babies Lives Care Bundle, a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
 - The national maternity early warning score (MEWS) and updated newborn early warning trigger and track (NEWTT-2) tools to improve the detection and care of unwell mothers and babies, enabling timely escalation of care.
 - NICE guidance, which sets out the evidence based best practice in maternity and neonatal care.
- 4.5 Our ambition is:
- Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities.
 - Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice care.
 - Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance.
 - Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines.
 - Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies.

How we will make this happen

4.6 It is the responsibility of trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.
- Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.
- Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.
- Complete the [national maternity self-assessment tool](#) if not already done, and use the findings to inform maternity and neonatal safety improvement plans.

4.7 It is the responsibility of ICBs to:

- Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.
- Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.
- Monitor and support trusts to implement national standards.
- Commission care with due regard to NICE guidelines.

4.8 NHS England will:

- Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.
- Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.
- Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.
- Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England.
- Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the [FutureNHS](#) platform.

Objective 11: Data to inform learning

4.9 The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects.

4.10 Our ambition is:

- Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.
- Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from [MBRRACE-UK](#) , and the [national clinical audits patient outcome programme reports](#).
- The [national maternity dashboard](#) provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work.

How we will make this happen

4.11 It is the responsibility of trusts to:

- Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.
- Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.

4.12 It is the responsibility of ICBs to:

- Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.

4.13 NHS England will:

- At a regional level, understand any variation in outcomes and support local providers to address identified issues.
- Convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.

- Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.

Objective 12: Make better use of digital technology in maternity and neonatal services

4.14 Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR). Most neonatal units use the same electronic product, which is designed for neonatal data capture, though some trusts and neonatal units are considering how to improve neonatal alignment with maternity and paediatrics as part of their EPR roll out.

4.15 Our ambition is:

- Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them.
- All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.
- Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.

How we will make this happen

4.16 It is the responsibility of trusts to:

- Have and be implementing a digital maternity strategy and digital roadmap in line with the [NHS England what good looks like framework](#).
- Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the [digital maternity record standard](#) and the [maternity services data set](#) and can be updated to meet maternity and neonatal module specifications as they develop.

- Aim to ensure that any neonatal module specifications include standardised collection and extraction of [neonatal national audit programme](#) data and the [neonatal critical care minimum data set](#).

4.17 It is the responsibility of ICBs to:

- Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.
- Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.
- Support regional digital maternity leadership networks.

4.18 NHS England will:

- Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.
- Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024.
- Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership.
- Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.
- Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.

Determining success for Theme 4

4.19 We will determine overall success by focusing on clinical outcomes:

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. We will monitor these measures nationally by ethnicity and deprivation.
- The progress measures we will use are:
 - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
 - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care.

- The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
- A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.
- The evidence that ICBs can use includes:
 - Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle.
 - An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
 - Progress against locally planned improvements.
- Relevant regulation and incentivisation includes:
 - The NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions.
 - The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.

Case Study: Ask A Midwife - using social media to communicate with service users

Ask A Midwife (AAM) is a social media messaging service managed by midwives, which empowers service users to make timely and informed decisions about their maternity care. AAM is coordinated centrally to ensure consistency of delivery and messaging by the Humber and North Yorkshire local maternity and neonatal system (LMNS), and four acute trusts are now working collaboratively to offer the service via Facebook, Instagram, and email.

The service is staffed by trust midwives who have a dual role in supporting the AAM service on a part-time basis alongside their clinical work. Questions from women and families range from pregnancy, birthing options, appointments, and the care of a new-born baby.

More than 94% of queries can be answered immediately and midwives can refer women to other health professionals and support organisations where required. The service routinely averages 800 queries per month, with more than 8,500 queries answered overall in 2022 and 508 onward referrals to health professionals, maternity units, NHS 111, and pharmacies. Patient confidentiality is conducted in the same way as telephone queries would be in a hospital, but the usual ways of contacting the hospital maternity team, such as by phone, are also available.

The service also allows the LMNS to cascade timely public health updates for pregnant women, including communications around vaccinations, perinatal mental health, postnatal care, and infant feeding. For example, when the AAM team saw an increase in messages around winter viruses they responded by posting self-help information.

AAM is promoted through Maternity Voices Partnership groups, with printed postcards and posters distributed in maternity settings, Children's Centres, through direct referral by midwives, and attendance at community outreach events, such as one in Spring 2023 specifically for people from the Romanian and Polish community.

Support available to staff, trusts, and systems

The maternity hub on the [FutureNHS platform](#) has relevant material for each theme.

Theme 1: Listening to and working with women and families with compassion

- [Personalised care and support planning guidance](#) and the [Personalised Care Institute](#)
- [Equity and Equality guidance for Local Maternity and Neonatal Systems](#)
- [NHS statutory guidance for working in partnership with people & communities](#)
- [National maternity voices partnership toolkit](#)
- [Service specification for care of pregnant and post-natal women in detained settings](#)
- [Delivering Midwifery Continuity of Carer at full scale](#)
- [Maternal medicine network national service specification](#)

Theme 2: Growing, retaining, and supporting our workforce

- [Nursing and midwifery retention self-assessment tool](#)
- [National preceptorship framework](#)
- [Advanced Clinical Practice: capability framework](#) for midwifery
- [RCOG advice and guidance](#) on workforce planning and flexibility
- A 'how to' guide and templates to reflect the [Core Competency Framework](#)

Theme 3: Developing and sustaining a culture of safety, learning, and support

- [Maternity and Neonatal Safety Champions toolkit](#)
- NHS [national freedom to speak up policy and guidance](#)

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- Support for quality improvement through [patient safety collaboratives](#)
- The [Maternity self-assessment tool](#)
- [The recommendations register](#)
- [NICE guidance](#)
- [Saving Babies Lives Care Bundle](#)
- An [MSDS guidance hub](#)
- For digital health there is [Digital Maternity Leaders training course](#) and the [Shuri Network](#) brings together women from minority ethnic groups

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- The Independent Working Group, chaired by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Members include:
 - British Association of Perinatal Medicine
 - Royal College of Paediatrics and Child Health
 - Royal College of Anaesthetists
 - Obstetric Anaesthetists Association
 - Society of Radiographers
 - Care Quality Commission
 - The Department of Health and Social Care
 - Health Education England
 - Service user voice representatives.
- Hearing from around 3,000 people via events and a survey. This included:
 - People who use maternity and neonatal services
 - National and regional service user voice representatives
 - Frontline professionals, including midwives, obstetricians, and neonatal colleagues
 - Integrated care boards
 - NHS England regional teams
 - Voluntary, community, and social enterprise organisations
 - National Guardian's Office
 - National stakeholders.

We remain committed to working closely with partners as we deliver this plan. Thank you to all the individuals and organisations who have shared their time, expertise, and experience so far.

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This publication can be made available in a number of alternative formats on request.