HOUSE OF COMMONS
LONDON SW1A 0AA

29 November 2017

Dear Colleague

Re: Improving safety in maternity services

As shown by the moving personal testimonies of colleagues in the House, and from the local cases you deal with, every child lost is a heart-rending tragedy that will stay with families for the rest of their lives. Thanks to the dedication and skill of NHS maternity teams, the vast majority of the roughly 700,000 babies born each year are delivered safely with high levels of satisfaction by parents. However, there is still too much avoidable harm and death – traumatic incidents too for the NHS staff involved. Brain damage sustained at birth can often last a lifetime - with about 2 multi-million pound claims settled against the NHS every single week. Stillbirth rates are falling but still lag behind many developed countries in Europe.

Our drive to improve the safety of maternity care began in 2015 when I announced a plan to halve the rate of maternal deaths, neonatal deaths, brain injuries and stillbirths. Last October, I set out a detailed strategy to support this ambition. Since then, over 80% of Trusts have a named Board level maternity champion. We have launched the Maternal and Neonatal Health Safety Collaborative to provide intensive training to Trusts on quality improvement science. Trusts are benefiting from a share of an £8.1m training fund and 25 Trusts are carrying out innovative projects supported by a £250,000 Maternity Safety Innovation Fund.

However, the Government's ambition is for the health service to be the safest, highest quality care available anywhere in the world - so there is much more work that needs to be done. I know this is an ambition shared right across the House. So this week I announced a series of additional measures to standardise best practice:

- **Healthcare Safety Investigation Branch 'Each Baby Counts' Investigations**: From April 2018 every case of a stillbirth, neonatal death, suspected severe brain injury that is notified to the Royal College of Obstetrician and Gynaecologists Each Baby Counts programme - about 1000 incidents annually - will be investigated with a thorough, learning-focused investigation conducted by the Healthcare Safety Investigation Branch (HSIB). The new independent investigations will involve families from the outset, and will have an explicit remit not just to get to the bottom of what happened in an individual instance, but to spread knowledge around the system so mistakes are not repeated.

- **Coroners' investigations:** Following concerns that some neonatal deaths are being wrongly classified as stillbirths, which means a coroner's inquest cannot take place, I will work with the Ministry of Justice to look closely into enabling, for the first time, full-term stillbirths to be covered by coronial law, giving due consideration to the impact on the devolved administration in Wales.

- **Rapid Resolution and Redress:** One of the current barriers to learning is litigation. Earlier this year, I consulted on the Rapid Resolution and Redress Scheme – which would offer families with brain damaged children better access to support and

compensation as an alternative to the court system. Today I am publishing a summary of responses to our consultation, which reflect strong support for the key aims of the scheme: to improve safety, patients' experience, and cost-effectiveness. The scheme will launch in 2019, with a view to introducing a full Rapid Resolution and Redress Scheme in order to reduce delays in delivering support and compensation for families.

- **Clinical Negligence Scheme for Trusts incentive scheme:** NHS Resolution spent almost £500m settling obstetric claims in 2016/17. Trusts which improve their maternity safety are saving the NHS money, making more money available for frontline care. In order to create a strong financial incentive on Trusts to improve maternity safety we will increase, by 10%, the CNST maternity premium paid by every maternity Trust - but refund the increase, possibly with an even greater discount, if they can demonstrate compliance with ten criteria identified as best practice on maternity safety by my Department's national Maternity Safety Champions.

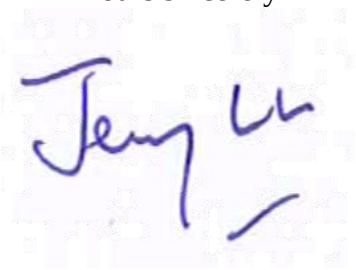
- **Training:** A new e-learning programme for healthcare professionals is being launched to help reduce avoidable causes of harm that can lead to infants born at term being admitted to a neonatal unit. We will also increase training for consultants on the care of pregnant women with significant health conditions.

- **Smoking prevalence**: Smoking during pregnancy is closely correlated with neonatal harm. Our Tobacco Control Plan commits the Government to reduce the prevalence of smoking in pregnancy from 10.7% to 6%, or less, by 2022, so we will provide new funding to train health practitioners such as maternity support workers to deliver evidence based smoking cessation.

- **Halving stillbirths by 2025:** Taken together, these measures give me confidence that we can bring forward the date by which we achieve a halving of neonatal deaths, maternal deaths, injuries and stillbirths from 2030 to 2025, which I am setting as the new target date for our 'halve-it' ambition. I will also include a reduction in the national rate of pre-term births from 8% to 6% within this ambition. In particular, we need to build on the good evidence that women who have 'continuity of carer' throughout their pregnancy are less likely to experience a pre-term delivery, with safe outcomes for themselves and their babies.

I would like to thank all of you who have given your time, attention and personal stories to support this work. Equally, your support to the valued NHS staff and organisations who are driving these improvements on the frontline is greatly appreciated. Please do feel free to share this letter with your local Trust and any constituents who may find this information useful.

Yours sincerely



Rt Hon Jeremy Hunt MP
Secretary of State for Health