



# Implementing a revised perinatal quality surveillance model

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# Purpose

The purpose of this paper is to set out the key principles for a revised perinatal clinical quality surveillance model. The actions set out should be implemented with immediate effect.

There are five principles for improving oversight for effective perinatal<sup>1</sup> clinical quality<sup>2</sup> to ensure a positive experience for women and their families. They integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

Revisions to the local, regional and national quality oversight model for the NHS are currently underway as part of the development of ICS and the future system oversight framework.

The principles set out in this paper are aligned to the route map set out in The NHS Long Term Plan, for health and care joined up locally around people's needs through ICS. From April 2021 this will require all parts of our health and care system to work together as ICS, involving:

- stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care
- provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale
- developing strategic commissioning through systems with a focus on population health outcomes;
- the use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

<sup>1</sup> In recognition that neonatal services are inextricably interdependent with maternity services, we refer to maternity and neonatal quality in terms of 'perinatal clinical quality' throughout this document.

<sup>2</sup> High quality care is understood, as per National Quality Board (NQB) definitions, to be care that is safe, clinically effective and which provides a positive experience for women. Additionally, in maternity, it is recognised that safe care can only be achieved when care is personalised.

Discussions for the integration of perinatal quality surveillance into local and regional oversight models should not be delayed and should be undertaken as part of these wider planning processes.

# Background

In response to the need to proactively identify trusts that require support before serious issues arise, a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services.

The provider trust and its board, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these. As the commissioners of maternity care, CCGs also have a statutory role to improve quality, safety and outcomes for their patients.<sup>3</sup> The quality model supports trusts and CCGs to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed.

The perinatal model is designed to function in the emerging architecture in the NHS, whereby ICS (with full involvement of providers and commissioners) will be responsible for system planning, governance and accountability, management of performance and reducing unwarranted variation in care and outcomes.<sup>4</sup> ICS are at different stages of development. It is, therefore, important that during this period of change, transitional arrangements for quality oversight are appropriate to each local system.

<sup>3</sup> NHS Commissioning Board – The functions of clinical commissioning group, March 2013.

<sup>4</sup> NHS England and NHS Improvement – Designing integrated care systems in England, 2019.

# Implementing the revised quality oversight model

## Principle 1 – Strengthening trust-level oversight for quality

Since 2017 all trust boards have been required to have a board-level safety champion, whose remit is to bring together a range of internal sources of insight to provide strategic oversight and leadership for perinatal safety. However, insight gathered from a range of system partners suggests that trust board oversight of perinatal clinical quality in provider organisations remains variable. Reasons for this include:

- perinatal clinical quality is not always reviewed regularly and methodically, using a consistent set of data and information
- variable understanding of maternity services on the part of board members
- variable effectiveness in different models of safety champion
- challenges representing perinatal clinical quality in a context of competing priorities.

We are therefore setting out six requirements to strengthen and optimise board oversight for maternity and neonatal safety:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

A range of further support measures are under consideration, including safety culture leadership training, access to a trust-level dashboard and access to an NHS Resolution developed annual maternity trust claims scorecard to help target interventions aimed at improving patient safety.<sup>5</sup>

## Principle 2 – Strengthening LMS and ICS role in quality oversight

NHS England and NHS Improvement are asking every system to be ready to operate as an ICS from April 2021, in line with the timetable set out in The NHS Long Term Plan. This will typically involve a single CCG aligned to each ICS. Currently 135 CCGs have statutory duties around the provision of high-quality maternity care. As CCGs merge and commissioning decisions become more streamlined across the ICS footprint, there will need to be a managed transition for quality oversight. NHS England and NHS Improvement regional quality and clinical teams have a key role to play in supporting this transition.

In The NHS Long Term Plan and NHS planning and contracting guidance for 2020/21, we described a set of consistent operating and governance arrangements that all systems should put in place by 2021/22. In the future model of quality oversight in the NHS, ICS will have oversight of quality surveillance, planning and improvement, accountable to NHS England and NHS Improvement regional teams. Local quality surveillance groups (QSGs) will be refreshed to align with ICS footprints, becoming the central mechanisms for ICS focused on supporting the ICS

<sup>5</sup> The scorecards are a quality improvement tool to assist with the analysis of clinical and non-clinical claims. Members may review claims data for all incidents occurring in the past five years. It also gives options for both clinical and non-clinical claims to view the type and cost and, specifically for clinical claims, to review the associated specialty/cause. The scorecard is a unique, interactive analysis tool in Excel which is underpinned by hard data.

to identify and monitor early warning signs and clinical quality risks, plan and coordinate action and inform quality improvement and transformation.

**Local maternity systems (LMS)** were established in 2017 to support the delivery of safer and more personalised maternity care. They bring together providers, commissioners, local authorities, service user voice representatives and other local partners to deliver a system plan. As the maternity arm of the ICS, they are ideally placed to oversee perinatal clinical quality.

As ICS evolve to become accountable for the quality and sustainability of services, the LMS should work with the ICS to take on a more formal role in perinatal clinical quality oversight alongside transformation and improvement activity. Given that maternity commissioning and oversight arrangements will be streamlined in ICS, it is expected that the LMS will be central to the new arrangements and that this will be reflected in local planning. CCG quality and contracting teams play a key role in quality oversight and integrated oversight is key.

LMS are at varying levels of maturity, with some operating more effectively in their maternity system leadership role than others. LMS that have met the Maternity Transformation Programme (MTP) ask that they are fully embedded in their STP/ ICS are likely to be better prepared. LMS will continue to receive financial support for the release of senior clinicians for local leadership and LMS implementation capacity up to 2023/24.<sup>6</sup>

## **Required actions for implementation of Principle 2**

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The LMS should support the ICS to oversee perinatal clinical quality by:

1. Ensuring an appropriately experienced and senior representative of the LMS (provider or commissioner with a clinical background) is a member of the ICS level local QSG.
2. Leading on the production of a local quality dashboard which brings together a range of sources of intelligence relevant to both maternity and neonatal services from provider trusts within the LMS.
3. Ensuring intelligence is shared and discussed regularly at meetings of the local surveillance group.

<sup>6</sup> [NHS Long Term Plan Implementation Framework](#), page 16.



4. Ensuring representation of perinatal quality issues at the ICS partnership board and the QSG as part of exception reporting.
5. Taking timely and proportionate action to address any concerns identified and building this into local transformation plans. The onus should be on trusts to share responsibility for making improvements, making use of strengths in individual neighbouring trusts within the LMS to ensure that learning and data gathered through perinatal improvement work is shared across the ICS to inform wider delivery improvement.
6. Reporting concerns to the regional chief midwife and lead obstetrician and regional quality committees, where necessary with a request for additional support.
7. Ensuring, as appropriate, that perinatal services are included in the quality objectives set by ICS, which are then reviewed regularly and updated.

## Principle 3 – Regional oversight for perinatal clinical quality

Each region has a quality committee or group which reports to the national Executive Quality Group. Each region also has a joint strategic oversight group (JSOG), which reports to the national JSOG. In both cases, these meetings are not maternity specific and are already in existence as part of standard quality oversight with regionally developed terms of reference. Exact names, remits and operating models vary between the regions and there is no support at regional level for standardisation. Going forward, the regional quality board should include maternity and neonatal quality as a standing agenda item to avoid perinatal quality being siloed, where issues for escalation to the national EQG, JSOG and national Maternity Safety Surveillance and Concerns Group are discussed and action agreed.

To role model the professional working and leadership responsibilities essential at the frontline and with the appointment of regional chief midwives with a leadership role in quality and safety, obstetric and neonatal leadership, expertise and insight is also essential to support high-quality care. While funding solutions are addressed to provide obstetric leadership in the long term, clinical network obstetric leads should be identified for each region, ensuring that responsibility for perinatal clinical quality oversight is a shared responsibility at regional level.

A mechanism for the regional chief midwife and lead obstetrician to gather insights from the range of stakeholders with insights into maternity and neonatal services will be required, to ensure the regional chief midwife and lead obstetrician are fully appraised of relevant issues to be brought to the regional quality group. This prior intelligence gathering is essential as regional quality oversight groups are responsible for overseeing a range of quality priorities across health and social care and would not be a suitable forum for ascertaining perinatal specific concerns first-hand.

Whatever the model of committee used to review perinatal clinical quality at regional level, it is important that it aligns to wider regional quality oversight, so that perinatal quality is not considered in isolation. This means that the regional chief midwife and regional lead obstetrician should be standing members of regional quality oversight groups and are routinely invited to raise perinatal clinical quality issues. This is particularly important given that maternity services may be an early indicator of organisational issues or wider service problems.

### **Required actions for implementation of Principle 3**

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**Perinatal clinical quality is routinely reviewed at a regional level committee, ensuring that:**

1. The region decides how this should be implemented, eg through a standalone perinatal committee or a dedicated standing agenda item on an existing committee, eg a regional quality committee.
2. The committee meet regularly, methodically consider perinatal clinical quality, marshal input from representatives with perinatal expertise and intelligence, ensuring that perinatal clinical quality is not considered in isolation, and escalate concerns to national level.
3. The regional chief midwife and regional lead obstetrician are standing members of regional quality oversight groups to avoid perinatal quality being siloed.
4. Oversight for perinatal clinical quality should involve the regional chief nurse, regional chief midwife and a lead obstetrician, who should work closely with regional neonatal leadership.
5. There is a formal process for gathering insights from multiple partners including the LMS, neonatal ODNs, maternity clinical networks, Maternity

Voices Partnerships chairs, CQC, NHS Resolution, HSIB, RCM, RCOG and where relevant, feedback from HEE, deaneries and coroners, providing the regional model with a helicopter view of perinatal clinical quality

6. Regular thematic reviews of perinatal clinical quality are undertaken.
7. Additional insights are informed by a regional quality dashboard which brings together a range of sources of intelligence.
8. Timely and proportionate action is taken to address any concerns identified. The initial response is likely to involve support for local resolution and action, with escalation used to gain additional expertise, leverage and resources to resolve the concern.
9. Once agreed through the regional committee and in agreement with the regional chief nurse, concerns should be reported by the regional chief midwife to the executive quality group and by the regional chief midwife and lead obstetrician to the new national NHS England and NHS Improvement-led Maternity Safety Surveillance and Concerns Group, where necessary with a request for additional support.

## Principle 4 – National oversight for perinatal clinical quality

The NHS England and NHS Improvement Executive Quality Group is the national governance group that oversees quality surveillance groups and receives escalations and reports. It is chaired by the National Medical Director and National Chief Nurse and attended by regional NHS England and NHS Improvement teams (medical directors, chief nurses, clinical quality directors), and national policy teams including patient safety, maternity, health and justice, specialised commissioning and primary care.

### **National governance has aligned to reflect the revised perinatal clinical quality model**

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A new Maternity Safety Surveillance and Concerns Group (MSSCG) was set up at national level in November 2020. It enables:

- the timely identification and escalation of any trust-level concerns by national partners with insights into maternity and neonatal services,

including HSIB, CQC, RCOG, RCM, RCPCH, DHSC, NMC, GMC, MBRRACE-UK, HEE and NHS England and NHS Improvement

- the sharing and gathering of intelligence from respective member organisations
- discussion around concerns in relation to trust compliance with the Maternity Incentive Scheme
- agreement on thresholds and means by which risks/cases of concern will be identified
- agreement on the most appropriate organisation to offer support, intervention and follow up on themes and/or concerns discussed
- agreeing appropriate levels of action where there are indications of a concern. Actions might include appreciative enquiry, monitoring, peer-to-peer support or, if criteria are met, entry into the Maternity Safety Support Programme
- agreeing timeframes for monitoring and follow-up
- ensuring appropriate, fair and consistent follow-up on cases/trusts at subsequent meetings or sooner if warranted
- Identifying themes which might require a national policy response and escalating this to the MTP.

The group is co-chaired by the Chief Midwifery Officer for England and the National Clinical Director for Maternity and Women's Health. To ensure issues and concerns are integrated into existing national structures, the chairs of the national MSSCG are core members of the national NHS England and NHS Improvement Executive Quality Group and the national JSOG, and will escalate issues of concern and any agreed action and support offer to these groups.

At national level, the current highest level of maternity-specific response involves placing trusts on the Maternity Safety Support Programme, which involves senior experienced midwives and obstetricians providing hands-on support to the trusts in question, through visits, mentoring, and leadership development. The MSSCG will oversee entry and exit to the Maternity Safety Support Programme.

## Principle 5: Identifying concerns, taking proportionate action and triggering escalation

Wherever possible, oversight, action and response should take place at provider level with the support of the safety champions and trust board, and other trusts in the LMS. A range of sources of intelligence should be drawn on to appraise the board that the quality of care is not deteriorating, by adopting a curious approach. Based on discussions and sharing of insights, identified issues should prompt collective decision-making drawing on the views of representatives on the board or committee as to responsibility, accountability and action.

Examples of intelligence which should warrant further enquiry ahead of a decision to escalate include but are not limited to:

- outlier status for perinatal and/or neonatal mortality
- concerns identified through the trust, board, LMS or regional dashboard
- thematic reviews identifying poor care as a contributory factor to outcomes
- service user concerns, including themes from the CQC maternity survey
- concerns raised by HSIB, NHS Resolution, through the Invited Review process, NMC, GMC and/or the deanery
- concerns raised by CQC
- themes from trainee or staff surveys
- triangulated data which suggests a need for further enquiry.

Action and support which may be considered when the need for additional intervention has been identified could include:

### Provider level

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- Discussion between frontline champions, MVP, board and non-executive lead to appraise, understand the issue, agree action, timeframes and follow-up.
- Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction.
- Issue discussed at the trust board and an action plan is agreed as a priority.

- Issue(s) discussed with LMS lead and regional chief midwife and action plan shared.
- LMS/ICS to support implementation of the action plan, escalating to regional teams if needed.

## **LMS/ICS level**

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- Appreciative enquiry and supportive approach to board safety champion and perinatal triumvirate by LMS lead and regional chief midwife to agree, implement and oversee progress with the action plan.
- Advice and support from the regional chief midwife and lead obstetrician with provision of resources, eg best practice documents and guidance.
- Support from MatNeoSIP if the issue lends itself to a QI approach.
- Peer-to-peer support from a provider trust within the LMS with a 'good' or 'outstanding' CQC rating.
- Mentorship from the clinical network.
- Access to specific training.
- LMS to share relevant learning.
- LMS to reflect relevant issues at ICS-chaired quality committee as agreed with trust and regional chief midwife and lead obstetrician.
- Regional chief midwife and lead obstetrician escalate to the regional chief nurse as required.

## **Regional level**

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- Relevant issues escalated to regional quality committee by the regional chief nurse, regional chief midwife and lead obstetrician.
- Action plan and progress with meeting the plan is provided.
- Advice and support from the regional chief midwife and lead obstetrician with provision of resources, eg best practice documents and guidance.
- Discussion on any additional action or support required is agreed by the regional quality committee. This might include regional quality Improvement team support, escalation to JSOG or an unannounced CQC inspection.

## National

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- Discussion on any additional action or support required and if criteria are met, entry into the Maternity Safety Support Programme.

## Criteria for entry into the Maternity Safety Support Programme

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Inclusion criteria	Exit criteria
<p><b>Maternity services</b> which have:</p> <ul style="list-style-type: none"><li>• an overall rating of Inadequate</li><li>• an overall rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led, or an inadequate rating in a third domain</li><li>• been issued with a CQC warning notice</li><li>• dropped rating from a previously Outstanding or Good rating to Requires Improvement in the Safety or Well-Led domains</li><li>• DHSC or NHS England and NHS Improvement request for a Review of Services or Inquiry</li><li>• been identified to the CQC with concerns by HSIB</li></ul>	<ul style="list-style-type: none"><li>• CQC improves the rating by at least one in the Safe and Well-led domains</li></ul>

Further work is being undertaken to refine examples of intelligence from a range of sources with guidance on thresholds for action, escalation and intervention. The exception is a CQC assessment which triggers automatic entry into the Maternity Safety Support Programme.

This approach provides transparency about the key areas of quality within perinatal services which could draw external review and possible scrutiny if not proactively managed, while ensuring that issues with a reasonable explanation are not escalated unnecessarily. It also ensures that responsibility for oversight and escalation is shared among the members of the board/committee.

# Conclusion

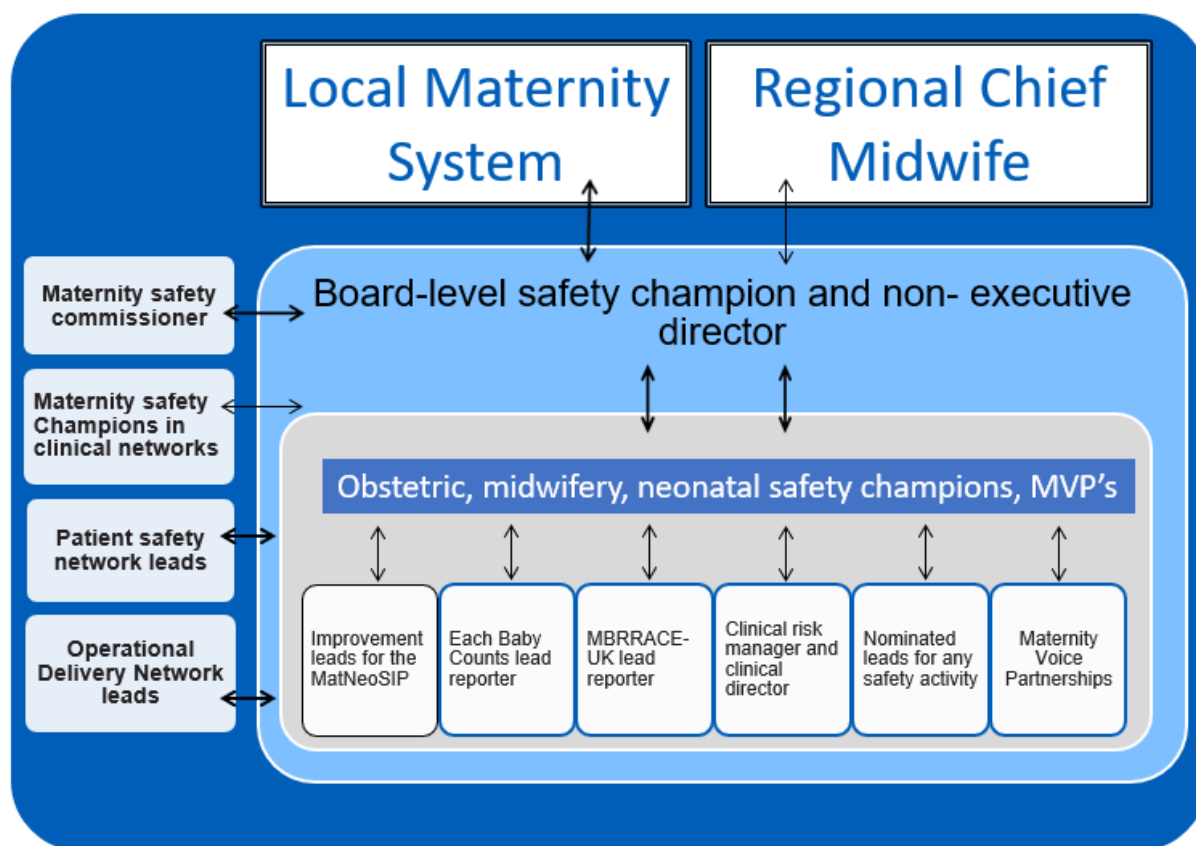
In summary, the proposals seek to improve:

- Trust board oversight, helping to ensure that issues are addressed in a timely fashion without the need for external intervention.
- Local oversight, by enhancing the role of the LMS through the ICS level local quality group, enabling a system-wide view of quality.
- Regional oversight, where specific insight from a range of system partners is linked into revising regional quality models through the chief midwife and lead obstetrician.
- Aligned national oversight, if interventions do not resolve the quality issue or if they are so serious as to warrant immediate escalation.
- At all levels of the model, the constituent parts have a clear sense of their role, remit and interventions at their disposal and of when to escalate issues.



# Appendix 1: Trust board oversight for quality drawing on multiple sources of intelligence

## Board safety champions



# Appendix 2: Minimum data measures for trust board overview

Select Trust:

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA
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	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool												
Findings of review all cases eligible for referral to HSIB.												
Report on: <ul style="list-style-type: none"> <li>•The number of incidents logged graded as moderate or above and what actions are being taken</li> <li>•Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training</li> <li>•Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.</li> </ul>												
Service User Voice feedback												
Staff feedback from frontline champions and walk-about												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

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