Spotlight on Maternity

Contributing to the Government's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030

March 2016

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Introduction

The purpose

Improving outcomes in maternity care has been an on-going priority for successive Governments. This Government has made reducing stillbirths an objective in the NHS England mandate and reducing deaths in babies and young children is a key indicator in the NHS Outcomes Framework.

On 13th November 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020.

The Government is now asking all organisations[1] with maternity services to consider committing to placing a spotlight on maternity and to make a public commitment to contribute towards achieving the Government's national ambition and improve maternity outcomes. This document is aimed at all individuals with a responsibility for delivering maternity care within these organisations.

This provides an opportunity for organisations to take stock of their current approach to improving maternity care, to celebrate the progress already achieved, and to build on this as part of a national focus. The aim is to enhance what is already underway and build momentum in order to make significant and sustainable progress over the next fifteen years.

The case for a spotlight

The NHS is already a safe place to give birth, but the death or injury of even one new baby or mother is a devastating tragedy which everyone working in the health and care system must do all they can to prevent.

Recent reports including the Morecambe Bay investigation, the MBRRACE-UK[2] reviews of maternal and perinatal deaths and the National Maternity Review: 'Better Births', highlight that there is more that can and should be done.

When compared to other high income countries, some maternity outcomes in the UK are unacceptable. In the recently published Lancet stillbirth series[3], the UK was ranked 24th out of 49 high income countries for stillbirth rates. The same publication showed that our rate of progress in reducing stillbirths has been slower than most other high-income countries.

High quality maternity services can and do make a difference. MBRRACE-UK's perinatal mortality surveillance published in June 2015 concluded that the variation in stillbirth rates across England cannot be explained solely by differences in known risk factors such as; poverty, ethnicity or the age of the mother.

Placing a 'Spotlight on Maternity'

There is evidence that having a concerted focus on patient safety across a particular care pathway can have a positive impact very quickly (Vincent and Amalberti 2016, Berwick 2013, Vincent 2010).

This document sets out five high-level themes which are known to make care safer (Vincent 2010, Berwick 2013, Woodward 2011, NPSA 2004) within each theme some key areas of focus are outlined.

If an organisation commits to place a spotlight on maternity then the Government is asking that they consider these focus areas when setting out their plans. Locally-led and self-directed improvement is vital and therefore any plans and actions should also be considered in the context of local services.

This is a working document and we anticipate that as we continue to learn from organisations and health professionals across the country further resources will be distributed via Sign up to Safety.

[1] For the purposes of this paper the term organisation is used to refer to a Trust, Foundation Trust, General Practice, and Independent Body
[2] MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
[3] http://stillbirthalliance.org/news/lancet-series-launch/

High Level Themes and Areas of Focus – A Summary

1. **Building strong leadership in maternity services by:**
    - Ensuring a board-level focus on safety in maternity
    - Setting up your maternity team to ensure a focus on safety
    - Developing a bespoke Safety Improvement Plan for maternity
2. **Building capability and skills for all maternity staff by:**
    - Improving communication within and across teams
    - Ensuring that all maternity staff complete and implement multi-disciplinary training
3. **Sharing progress and lessons learnt across the system by:**
    - Sharing your Safety Improvement Plan and progress publically
    - Sharing what you are learning so that others can benefit
    - Helping create a national picture by contributing to the Government's annual report
4. **Improving data capture and knowledge in maternity services by:**
    - Improving the collection and reporting of high quality data to national data collections
    - Ensuring that your service follows national guidelines for patient safety reporting
5. **Focusing on early detection of the risks associated with perinatal mental illness by:**
    - Ensuring that all staff that work in maternity services are trained to identify the risks and symptoms of mild to severe perinatal mental illness
    - Ensuring that all staff that work in maternity services are aware of the local perinatal mental health pathways of care.

Theme One: Building strong leadership in maternity services

- **Ensuring a board-level focus on maternity**
- **Setting up your maternity team to ensure a focus on safety**
- **Developing a bespoke Safety Improvement Plan for maternity**

A spotlight on maternity will only be successful if each organisation has strong, supportive leadership, a clear plan and a core team of people who are responsible for taking the ideas forward (Vincent and Amalberti 2016, Berwick 2013, NPSA 2004).

1.1. A board level focus

All organisations should ensure that there is a board-level focus on improving safety and outcomes in maternity services. Organisations should also provide the opportunity for the Medical Director for maternity and the Head of Midwifery to present regularly to the board.

Organisations are already expected to have an executive sponsor for patient safety at Board level. These senior leaders should regularly review the safety improvement plans at their Board or leadership meetings. Existing roles could be reviewed to ensure they cover maternity care, or new roles could be created.

These senior leaders should be visible to the frontline, listening and learning directly from staff. A long-term culture change and continual improvement often comes from what leaders demonstrate through their commitment, encouragement, compassion and modelling of appropriate behaviours (Vincent and Amalberti 2016, Hollnagel 2014, Berwick 2013, Vincent 2010).

1.2. Setting up your maternity team to ensure a focus on safety

All organisations should ensure that there is a core team of people who are responsible for taking the agreed actions forward.

Most organisations will already have a core team of people who are working on quality and safety. Organisations could bring this work together under the banner of Sign up to Safety in an existing team or create a specific work-stream for maternity. It will work differently for different services but there are benefits of placing accountability with those who are delivering the services.

Each member of the Sign up to Safety campaign has appointed Safety Leads and these leads could act as a conduit for all campaign communications and resources. Those leads can help reach out to the maternity teams in their organisations by forwarding useful Sign up to Safety resources, as well as encouraging individuals who work in maternity to sign up for themselves.

1.3 Developing a bespoke Safety Improvement Plan for maternity

All maternity services should develop a bespoke maternity Safety Improvement Plan which brings together existing and new plans into one place.

A Safety Improvement Plan is a document which sets out the organisation's plans for the next three to five years in relation to quality and safety. This should include a clear statement as to how a reduction in avoidable harm in maternity will be achieved (Vincent et al 2014, Vincent 2010).

There are several benefits of a bespoke maternity Safety Improvement Plan:

- It helps the staff in the organisation to be clear about what they want to achieve and when they want to achieve it by.
- It enables all the current work on quality and safety in maternity to be collated in a single place which is easily accessible.
- It can be discussed at the organisation's leadership team or Board.
- It can be used as evidence for anyone who wishes to find out what the organisation is doing to improve the safety of maternity care.

Many organisations will already have bespoke maternity plans and if you are already working on maternity care as part of your Safety Improvement Plan then you should continue with this work but revisit the plan in light of the national ambition.

If maternity care is not covered in your Safety Improvement Plan and you are committing to place a spotlight on maternity then you will want to review your current organisational wide plan to include a section on maternity or develop a separate bespoke maternity Safety Improvement Plan.

Helpful Resources

For help in creating your plan see the Sign up to Safety website: www.signuptosafety.nhs.uk

For further information on measurement of Safety Improvement Plans see the Sign up to Safety webinar library: www.signuptosafety.nhs.uk/webinars

For inspiration on how other organisations have showcased improvement work please see the 'From the frontline' section on the Sign up to Safety website: www.signuptosafety.nhs.uk

Theme Two: Building capability and skills for all maternity staff

- **Improving communication within and across teams**
- **Ensuring that all maternity staff complete and implement multi-disciplinary training**

Continuous learning and training for staff will have a positive impact on performance (Berwick 2013, NPSA 2004). The aim should be to increase the skills and knowledge of the maternity workforce with a focus on improving outcomes.

2.1. Improving communication within and across teams

All organisations should consider the use of safety briefings and review how shift handovers are undertaken

A crucial part of improving patient safety is to improve the communication and information dissemination within and across teams (Vincent and Amalberti 2016, Woodward 2011, NPSA 2004).

2.1.1 Safety Briefings

Safety briefings help to connect people within the team and drive the culture change needed to improve safety and quality across the board (Woodward 2011). There are several different types of safety briefings, each have their own benefits and should be used at the appropriate time to ensure maximum impact (IHI 2016).

Types of safety briefings

- Proactive – held to discuss staff concerns and act on these as appropriate with the aim of preventing patient safety issues occurring. These will also help to create an open culture within the team
- Reactive – triggered by a specific event to quickly assess how it could have been prevented, what can be learnt from it and what could be done differently in the future
- Formalised – planned at specific times with attendance mandatory for a designated team
- Information capturing/sharing – an opportunity to share relevant information with others in the team, for example a list of all patients on the ward with infections or a list of women who are at risk of perinatal mental illness
- Unplanned impromptu – called at any time by any member of the team to regroup or seek collective advice on a particular issue.

2.1.2 Shift handover briefings

Often held at the beginning and end of shifts, shift handover briefings provide an opportunity to have a proactive discussion about any concerns and to share things that are working well, as well as a chance to discuss relevant information about the individuals on the ward.

It is important that both safety briefings and handovers are set up to fit within the structure of the organisation and are helpful for the staff in the maternity team. There are some key points that should be considered when implementing safety briefings or handovers (Cracknell 2015). These are:

- Make them brief and clear
- Know when to make them multi-disciplinary or uni-disciplinary
- Make sure they are helpful and focused and create a shared understanding of what is needed and when
- Use a communication framework for ensuring all the information is shared consistently and as quickly as possible
- Allow an opportunity for individuals to ask clarifying and open questions
- Provide an opportunity for a debrief

Helpful Resources

You can access free webinars where safety briefings are discussed in depth in the Sign up to Safety webinar library: www.signuptosafety.nhs.uk/webinars

You can also find free, printable 'how to' guides on safety briefings in the 'Latest thinking' section of the Sign up to Safety website: www.signuptosafety.nhs.uk

2.2. Ensuring that all maternity staff complete and implement multi-disciplinary training

All organisations should focus on increasing the capability and skills of their maternity teams by ensuring that all maternity staff complete and implement appropriate training programmes.

Each organisation should begin with identifying any gaps in training and development for the staff in the maternity team. When identifying these gaps it is advisable that you work with all staff to ensure an accurate understanding. Based on this information you will be able to develop and implement a learning and development plan for the entire multi-disciplinary team.

Key areas that could be focussed on when developing these plans are; obstetric emergencies, multi-disciplinary team working and an enhanced understanding of human factors related[4] to patient safety.

Further Information

- See Health Education England via: https://hee.nhs.uk/our-work/hospitals-primary-community-care/learning-be-safer/commission-education-training-patient-safety

Health Education England – Maternity Safety Programme

The Department of Health has commissioned Health Education England (HEE) to develop a maternity safety training programme. A Maternity Safety Steering Group (MSSG) has been established which will provide recommendations to HEE on maternity safety and agree a set of options for training programmes. This will help to ensure that there is standardisation of training nationally.

The MSSG will have a key role in ensuring education and training programmes are fit for purpose and that trusts are aware of the key packages of education and training available for the maternity workforce. The group will also ensure that training materials are reviewed and updated in line with the latest clinical best practice.

[4] Human Factors is a term used in patient safety to refer to those factors that help or hinder safety such as team work, relationships, communication, handover, observations and design (of services, equipment or pathways)

Theme Three: Sharing progress and lessons learnt across the system

- **Sharing your Safety Improvement Plan and progress publically**
- **Sharing what you are learning so that others can benefit**
- **Helping create a national picture by contributing to the Government's annual report**

3.1. Sharing your Safety Improvement Plan and progress publically

Your bespoke maternity Safety Improvement Plan should set out clearly how you will make the improvement plans public and how you will share progress.

All those who have joined Sign up to Safety have already pledged to be open with their progress in patient safety, and the spotlight on maternity is a great chance to continue to do so. It is suggested that you use the annual Quality Accounts process as a place to consolidate progress against your Safety Improvement Plans.

3.2. Sharing what you are learning so that other organisations and health professionals can benefit

Organisations should, where appropriate, host and attend events to share best practice and learning. This could be in small groups of local services or on a national scale.

One of the aims of this work is to create a learning culture across organisations and networks so that best practice can be shared and adapted in other services. This could be done by, for example, creating mini-campaigns to raise awareness, organising events and inviting staff to be involved and celebrate progress.

3.3. Helping create a national picture by contributing to the Government's annual report

The Government is asking all organisations who sign up to the spotlight on maternity to contribute to its planned annual report on the 2030 ambition

Each year the Government intends to publish a report on progress on the national ambition.

Further information will follow from the Department of Health about the plans for the report and the progress of reporting.

Sign up to Safety Webinars

You can take part in Sign up to Safety webinars which enable you to share your work. Please find more details at: www.signuptosafety.nhs.uk/webinars

Theme Four: Improving data capture in maternity services

- **Improving the collection and reporting of high quality data to national data collections**
- **Ensuring that your service follows national guidelines for patient safety reporting**

Accurate and consistent data collection is vital. Unless outcomes can be measured across the NHS, the ability to understand where progress needs to be made or when it has been made will be limited.

It is also important to capture information when things go wrong and use this to learn from. This can include through case note reviews, clinical audits, patient safety incidents, serious incidents, never events, complaints and claims.

4.1. Improving the collection and reporting of high quality data to national data collections

All organisations should ensure that there is appropriate collection and reporting of high quality data across their maternity services.

In November 2015, the first statistics from the Maternity Services Dataset (MSDS) were published. Organisations should ensure that their maternity information systems are compliant with the Information Standards Notice for reporting to MSDS so they are able to contribute to this dataset.

There are also additional areas of reporting that organisations can use to capture relevant data, these include:

- The Maternity Safety Thermometer[5]
- Data collection process for MBRRACE-UK enquiries[6]
- Data collection processes for Each Baby Counts which is led by the Royal College of Obstetricians and Gynaecologists[7]

4.2. Reporting appropriately when things go wrong

All organisations should ensure that they follow national guidelines for patient safety reporting.

Quality of care should improve as organisations learn from error and adapt their procedures as appropriate to reduce avoidable harm. A review process can also provide good information for parents and families about why the mother or baby was harmed or died.

Organisations should ensure that they are set up to report to the National Reporting and Learning System and that they are compliant with the Serious Incident Framework and the framework for Never Events.

When things go wrong organisations should also adhere to the principles set out in the Royal College of Obstetricians and Gynaecologists *Green top Guidelines* for example that of *Later Intrauterine Fetal Death and Stillbirth.*

Further Information

- National Reporting and Learning System: www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/
- Serious Incident Framework: www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
- Never Events Framework: www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf
- RCOG Guidelines: www.rcog.org.uk/globalassets/documents/guidelines/gtg_55.pdf

[5] https://www.safetythermometer.nhs.uk/
[6] https://www.npeu.ox.ac.uk/mbrrace-uk
[7] https://www.rcog.org.uk/eachbabycounts

Theme Five: Early detection of the risks associated with perinatal mental illness

- **Ensuring that all staff that work in maternity services are trained to identify the risks and symptoms of mild to severe perinatal mental illness**
- **Ensuring that all staff that work in maternity services are aware of the local perinatal mental health pathways of care**

We know that 10-20 per cent of women develop a mental illness during pregnancy or within the first year after giving birth and 4 in every 1000 women will experience complex or severe perinatal mental illness requiring psychiatric in-patient care in a specialist mother and baby unit.

Perinatal mental illness is one of the leading causes of death for mothers during pregnancy and the year after birth and therefore improvements in care in this area will contribute significantly towards reducing maternal deaths. A mother's perinatal mental illness has also been shown to affect the emotional, cognitive and even physical development of the child.

The Government is committed to improving perinatal mental health services for women so that they are able to access the right care at the right time and close to home. Between 2015-2016 and 2020-2021, the Government has committed to make available a total of £365m for improving perinatal mental health services. This builds on initial investment announced in March, making a total investment from 2015/16 to 2020/21 of £365 million.

5.1. Ensuring that all staff that work in maternity services are trained to identify the risks and symptoms of mild to severe perinatal mental illness

All organisations should review, and if necessary improve, the training and support provided to their maternity staff to ensure the early detection of the risks associated with perinatal mental illness.

It is clear that improving perinatal mental health care is not the responsibility of one discipline or team and it involves a range of health professionals including; midwives, health visitors and GPs, as well as specialised perinatal mental health teams.

E-learning modules

In February 2016 Health Education England (HEE) launched four e-learning modules to support all NHS health professionals in enhancing their understanding of perinatal mental illness.

The modules are available on the eLFH platform and HEE is currently working with the Royal Colleges and key stakeholders to raise awareness of the modules. Organisations should encourage all of their maternity staff to complete the modules as part of their learning and development.

5.2. Ensuring that all staff that work in maternity services are aware of the local perinatal mental health pathways of care

All organisations should review, and if necessary improve, the information available to their maternity staff to ensure they are aware of local perinatal mental health pathways of care.

NICE guidelines set out that there should be clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the first year after birth know how to access assessment and treatment. They also state that staff should have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways.

Further Information

- More details on the NICE guidelines are available at: www.nice.org.uk/guidance/cg192/chapter/1-Recommendations#the-organisation-of-services-2
- E-Learning for healthcare website: www.e-lfh.org.uk

Spotlight on Maternity – Next steps

The spotlight on maternity is about a fresh spirit of openness, improved learning, greater transparency and a renewed focus on working together to improve outcomes for mothers, their babies and their families.

Organisations can now help to build momentum by placing a public statement on their website which demonstrates that they are committed to contributing to achieving the national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030.

This is a long term ambition and it is important to note that improvements in outcomes may not be seen immediately and real embedded change will take time.

As a first step, organisations should now develop bespoke maternity Safety Improvement Plans with tangible actions that they can begin to put in place in the coming months.

Sign up to Safety - Help and Support

Halving avoidable harm is at the very heart of Sign up to Safety and they work in partnership with other organisations to ensure that interventions that effect frontline care are co-ordinated and aligned.

With this new spotlight on maternity, there is an opportunity for Sign up to Safety to help those delivering maternity care across the NHS to ensure safe care and improve outcomes for mothers and their babies.

Fifty member organisations of Sign up to Safety have already included maternity specific improvement projects in their Safety Improvement Plans. Through the campaign's network of over 340 signed up organisations, Sign up to Safety will reach out to support this work and in particular the maternity teams and help them build on their existing improvement work.

This guide will join a host of other useful resources and tools collated by the Sign up to Safety team which are easily accessible at www.signuptosafety.nhs.uk/maternity.

Sign up to Safety will host regular, free webinars and provide ways for people to share and showcase their progress. Support will also be signposted via the weekly, free SignUPdate newsletter and campaign twitter account.

For Further Information:

- Please see your local Sign up to Safety lead or:
- Email: signuptosafety@nhsla.com
- Website: www.signuptosafety.nhs.uk/maternity

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Annex A - Example Checklist for your Safety Improvement Plan

Step	Action	✓
People	• Nominate an Executive sponsor or senior lead from your organisation or practice to provide board leadership • Nominate one or more Safety Leads • Identify the people you want to lead on the areas of harm you want to reduce • Identify a core team of staff who will support them to implement the plan	
Champions	• Identify the clinical and managerial role models in your organisation are that could help promote your plan	
Your plan – the basics	• Provide a clear 'aim statement' for your plan with individual aims for each of the areas that are important to you; focus on doing a few things well • Create a driver diagram for each area and set out how you will measure what you are doing • Describe your milestones and deliverables for year one • Set out what data you want to collect and where possible record the qualitative and quantitative data retrospectively • In order to understand your safety culture and create some baseline data you may want to conduct a patient safety culture survey • Describe the roles and responsibilities for the team • Set out how it builds on your existing quality and safety plans • Set out how you will implement your plan and how you will spread the work as appropriate, this includes a timeline of activity divided up into 90 day plans	
Increasing skills to support your plan	• Consider a training programme on improvement and measurement skills for reducing harm and improving safety • Consider a learning plan for how you will increase the understanding of improvement skills, patient safety and a safety a culture together with human factors across your organisation	
Sharing knowledge, scale up, spread	• Create a communications plan for how you will share your safety improvement plans and progress with your staff and the public via your website • Align with the central campaign activities and run mini-campaigns in your organisation to raise awareness of what you are doing and showcase your work to your staff and the public • Share progress with the central campaign team who can highlight your success and share your tips, tools, documentation with the wider community via our webinars and website • Connect with your local academic Health Science Network • Set out how your plan will spread across departments or across the health economy via commissioners for example	

Annex B - National Reports – The Evidence Base

- Perinatal Mortality Surveillance Report UK Perinatal Deaths for births from January to December 2013
  www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Surveillance%20Report%20 2013.pdf

- MBRRACE-UK 2015 Perinatal Confidential Enquiry Term, singleton, normally-formed, antepartum stillbirth
  www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Report%202015.pdf

- Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13
  www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015.pdf

- The Report of the Morecambe Bay Investigation
  www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf