Ipswich and East Suffolk
Clinical Commissioning Group

GOVERNING BODY

Agenda Item No.	**07**
Reference No.	**IESCCG 19-39**
Date.	**23 July 2019**

Title	**Maternity Transformation Programme Overview**	
Lead Chief Officer	Lisa Nobes, Chief Nursing Officer, Suffolk CCG's	
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Purpose	To present an overview of the Maternity Transformation Programme	
Applicable CCG Clinical Priorities:		
1.	To promote self care	
2.	To ensure high quality local services where possible	✓
3.	To improve the health of those most in need	
4.	To improve health & educational attainment for children & young people	✓
5.	To improve access to mental health services	
6.	To improve outcomes for patients with diabetes to above national averages	
7.	To improve care for frail elderly individuals	
8.	To allow patients to die with dignity & compassion & to choose their place of death	
9.	To ensure that the CCG operates within agreed budgets	✓

Action required by the Governing Body:

The Governing Body is asked to note the report.

1. Introduction

1.1 Maternity and neonatal services were subject to a national review during 2014/15; resulting in the five year forward view for maternity services being produced (named Better Births). Further guidance related to the reducing maternal and neonatal deaths, prematurity, and birth complications was issued. Three significant documents were published:

- Better Births - Improving maternity outcomes - Five year forward view for maternity services 2016
- Saving Babies Lives care bundle 2016
- NHS Improvement Neonatal Health and Safety Collaborative Programme 2017

1.2 The targets within these documents have been brought together to formulate the **national maternity transformation programme**. The programme must be implemented at a system level, to ensure consistent levels of provision and outcomes.

1.3 It is a complex programme of work with challenging targets within now relatively short timeframes. This programme requires significant transformation input and monitoring, to ensure the Suffolk and North East Essex Local Maternity System (LMS), the ICS and NHSE are assured of delivery, in a timely and safe manner.

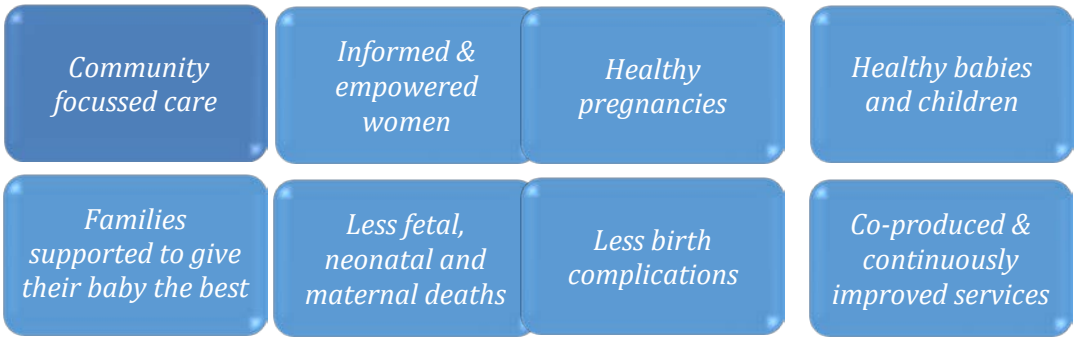
2. Why? - Outcomes for our Population

2.1 The transformation programme has a number of intended outcomes for our population:

2.2 The predicted clinical outcomes of implementing the national programme are significant, with a likely:

50% reduction in stillbirths, neonatal deaths, maternal death, and babies born with brain injuries;
16% reduction in pregnancy loss, and **24% reduction** in pre-term birth.

2.3 Less invasive and intensive interventions during births are also expected to increase because of the transformation. So women will be less likely to require local analgesia/epidural (**15% reduction**) or an episiotomy (**16% reduction**), both of which can delay women from returning to normal activities.



2.4 Women will be **more likely** to have a home birth or midwife led care.

2.5 Most importantly, it should **improve the care experience** for women during pregnancy and birth, and the health outcomes for the child and mother postnatally.

2.6 Locally, the care pathways currently being developed are also aimed at achieving:

- Higher breastfeeding rates
- Improved smoking cessation
- Improved diabetes prevention
- Improved communication about safeguarding concerns and issues
- Improved emotional wellbeing and support networks

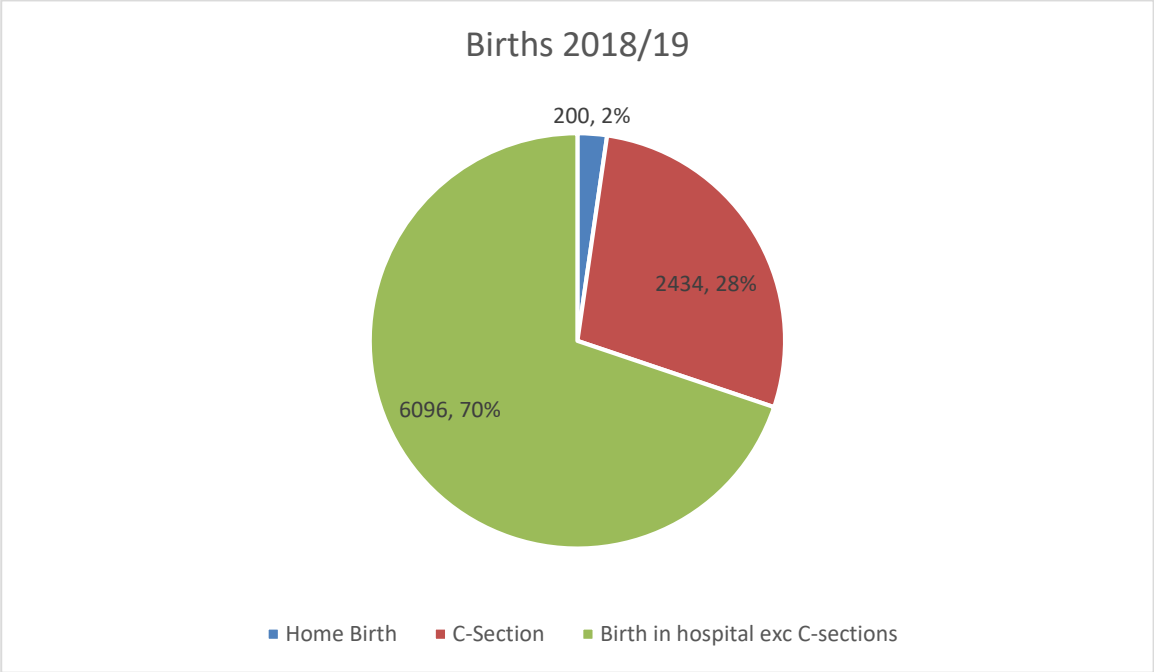
2.7 These outcomes could provide meaningful changes to the people living within our system. The **possible** societal impact of these outcomes could include:

- less children who require SEND and continuing care input
- healthy and supported parents
- less emotional and physical stress on families due to positive pregnancies and birth outcomes
- parents who can return to work instead of needing to stay at home to care for a child with long term conditions/complex disabilities,
- improved educational attendance and attainment due to less children with long term illnesses or brain injury, and
- ultimately, more children who can develop into healthy adults, who can access employment, support their community and bring families of their own into the world.

2.8 There will be potential monetary savings through less extensive interventions during the baby's birth.
The costs of individual interventions are as follows:

Intervention	**Cost per woman 2018/19**
Epidural	£1200
neonatal stay per 24 hours (for pre-term birth)	£ 284
normal hospital delivery without epidural	£4321
normal home delivery without epidural	£2514 (financial saving of £1807)

2.9 To put this into perspective in 2018/19 we had 8674 births (excluding One to One births) within the ICS population, with the following breakdown of birth locations:



2.10 A 5% increase in home births would offer a potential £783,696 saving as well as enabling women to birth in a natural, familiar and relaxing environment.

3. What? - Maternity Transformation Programme

3.1 The clinical outcomes mentioned above are obviously broken down into a set of deliverables (see Appendix A for detailed list), which are based on evidence based practice and learning from pioneer sites.

3.2 The transformation programme requires current pathways and working patterns to be radically changed. Co-production is essential in all areas of the transformation, co-produced with our workforce and users. There are three Maternity Voice Partnerships (MVP), one per Alliance, who represent families and users of the services. The MVP's are proactive in their own right, but also have a seat at the LMS Board, and are actively involved in the entire transformation programme. Supporting the main work streams detailed below are task and finish groups focussed on workforce planning and development, engagement, digital, outcome evaluation framework, and estates.

3.3 The main pillars of the transformation programme are:

Personalised Care	**Continuity of Carer**	**Safety**	**Postnatal Care**
100% women to have Personalised Care Plans by March 2021 Dynamic Digital maternity record will provide unbiased information to inform care planning, and to enable women to make informed choices about their care	100% women to have the same/buddy midwife throughout the pregnancy, birth and postnatal care by March 2025 20% by 03/19 35% by 03/20 50% by 03/21 100% by 03/25 Each team of	50% reduction still, neonatal deaths, maternal deaths and brain injuries births by 2025 Implementation of the Saving Babies Lives bundle by 2020 Rapid referral to other disciplines	Postnatal improvement plan by October 2019 Investment in perinatal mental health services Postnatal care resourced appropriately, including midwife care up to 28 days post

Women to be informed about their choice of care provider and location of birth Community hubs available to meet with midwives and other appropriate services by March 2020	midwives to have an identified obstetrician	Neonatal care transformed through the Critical Care Review recommendations National standardised investigation process Clinical outcome review and continuous improvement Local Learning Systems established to review and improve practice	birth Seamless pathways for transition to health visiting and specialist services

4. How? – Programme Delivery and Risks

4.1 A programme plan is in place to track delivery of all milestones. Progress is monitored monthly by the LMS Board, and reported within the programme highlight reports to STP Board.

4.2 The LMS provides bi-monthly assurance to the regional NHSE team, by assessing our achievement against the key deliverables. **SNEE is currently is on track with all deliverables.** There are however some risk to delivery:

a) Continuity of Carer (CoC)

Continuity of Carer requires a higher ratio of midwives:women. Whilst investment is required into the additional workforce, there will ultimately be savings to the system when the system and clinical outcomes (described above) are achieved.

NHSE has commended SNEE LMS for its innovative and sustainable approach to rolling out CoC. The LMS funded a CQC recognised workforce planning tool to enable the three maternity units to analyse their acuity of care, and subsequent workforce needs. However, the service model needed to be implemented before the planning tool could report on its recommendations. Six engagement events were therefore held across the ICS to engage with the maternity workforce, medics and service users to gain ideas of how the model could be implemented. The events recommended which services would become the early implementers, and volunteer midwives were recruited to deliver the teams. The LMSB made a decision to provide short term investment to enable the additional midwife hours to be resourced. During the period of funding, the model will be evaluated and cross referenced to the workforce planning tool, to enable the LMS to inform commissioning intentions and business planning cycles for 2020/21. The midwives from the early implementer teams (wave 1) have become champions of the model and are working with midwifery colleagues to develop the next wave of teams.

A National data collection exercise was completed in March 2019 to evidence whether the target of 20% of women receiving continuity of care for them during pregnancy, birth and postnatally had been attained. SNEE achieved 34%; however, this included a large number of women moved across onto the pathways during March 2019. If these women were extracted from the data, the overall average was 9%. This is line with the majority of LMS across the country.

The wave 1 teams have received extremely positive feedback from women, their partners and health colleagues. (see appendix B for feedback given to the Venus team).

The next target (articulated in the NHS Long Term Plan), is to achieve 35% of women by March 2020. The LMS are developing plans for the wave 2 teams to enable sufficient increase in women receiving CoC care, from 9% to 35% by March 2020. This is a huge challenge. Again, the LMS has agreed to fund backfill for all three maternity sites to assist in achieving this steep increase during 2019/20. However, substantive money will need to be found to fund these additional staff members.

It is also unknown whether there are sufficient numbers of trained midwives available within the economy to increase the workforce by the required amount. The Midwifery Support Worker role is being expanded to facilitate the model, but the specialist nature of the care is predominantly dependent on qualified midwives coming into post. The LMS is supporting the Heads of Midwifery to develop workforce development plans to establish how (as a system) we can attract sufficient midwives to our area.

b) Saving Babies Lives audit

Saving Babies Lives is focussed on delivering services in a manner that can reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries. It concentrates on:

- reducing smoking in pregnancy,
- risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
- raising awareness of reduced fetal movement,
- effective fetal monitoring during labour.
- reducing preterm birth (new requirement added in March 2019)

Process and outcome indicators accompany all five elements. The LMS was required to submit a clinical audit to NHSE/I in March 2019. The feedback indicated that the LMS was considered to **require "support"** to achieve a consistent provision across the LMS. An LMS action group is under development to respond to the audit feedback, and to address the additional Saving Babies Lives requirement of reducing preterm birth. All LMS' must be compliant with the entire care bundle by March 2020. It is unknown whether investment is required into this area of practice. For example, WSFT have not been able to provide the additional level of scanning resource required to deliver the new pathway. To enable compliance and improving outcomes investment may be required in both capital and revenue resource. Resource requirements will be scoped within the action planning process.

c) Digital Maturity

Better Births states that a digital maternity tool should be in place to implement the following:

- Digital access to unbiased information to enable the service user to make informed decisions
- A dynamic electronic care plan, kept up to date as pregnancy progresses
- Service user access to their own maternity record, and ability to update it
- Information on local services
- Data collection on quality, outcomes and performance
- Enable smooth transition and sharing of information between midwife, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor

The digital tool will underpin the personalised care and choice agenda, with the ultimate aim of providing patient centred care, and increasing the number of women giving birth in a midwife led setting. It is therefore a critical tool to enable the transformation programme to be realised.

Currently within the LMS, there are varying levels of technology used within the maternity services:

- Colchester Hospital site have Medway electronic record,
- Ipswich Hospital use paper records and have hand held notes,
- West Suffolk Hospital use paper records and have hand held notes, but have plans to roll-out e-Care within 2019/20, and
- One to One have a bespoke electronic record insitu.

The LMS procured an impartial assessment of our digital readiness to achieve these milestones. It recommended that:

- Ipswich Hospital site to adopt Medway electronic notes system in line with its sister site and introduce an archiving system for CTG/scans
- Investment is made into IT equipment to enable midwives to be delivering the required models of care in the community
- ICS digital developments are progressing, but are not quite ready to provide the required platforms to enable the digital maternity needs to be met. An APP will therefore be used for three years to enable progress be made on personalised care planning.

The APP (and 3 year maintenance plan) has been purchased by the LMS. The remaining actions are the responsibility of the provider trusts. The Director of Midwifery is undertaking internal discussions to establish whether funding can be assigned to these essential tools.

5. How? – Resources and Assurance Frameworks

5.1 **Financial Plan for 2019/20** (See appendix C for Full Plan)
The financial plan has been focussed on trying to achieving the higher priorities/mandatory targets and highlighted risks within the four pillars:

Area of Spend	Amount	Pillar	Rationale
Continuity of Carer	£602,000	Continuity of Care	Extension of the original ESNEFT wave 1 teams from six to 12 months (8wte) Wave 2 teams at ESNEFT and WSFT (7wte) (Oct 19 – Mar 20).
Mum and Baby App	£54,500	Personalisation	To achieve two national deliverables, and immediate start to introducing the choice agenda for women within SNEE.
Co-Production	£33,000	All Pillars	Support the three Maternity Voice Partnerships to actively engage with families, and to take a lead role in service transformation.
Whose Shoes	£15,000	All Pillars	Continuous improvement tool, an essential element of the maternity programme
Engagement	£4500	All Pillars	To engage with women & families to promote the changes made, to promote healthy pregnancy messages, and promote the choice agenda
Programme Leadership	£157,000	All Pillars	Clinical lead posts (see below), programme manager, and an admin post (to be recruited summer 2019).
Alliance Project Leadership	£50,000	All Pillars	Part-time project management within the Alliances to ensure localised implementation of the programme, to co-ordinate Alliance maternity forums, and address localised performance.
Total	**916,000**		

5.2 Maternity transformation would like to work with ICS partners to establish whether the following critical areas of transformation could be funded. There was insufficient funding from NHSE to cover these areas, but they are seen as key to achieving the ambition of **providing the best start in life** for our population.

Neonatal Care	£15,000	Safety	Clinical lead for one day a week to interpret new national guidance and inform action planning.
Postnatal Care	£6000	Postnatal Care	To purchase equipment, training or for a deep dive exercise to be completed.
CoC Related equipment	£100,000	Continuity of Care	Clinical and IT equipment necessary to deliver the service
Saving Babies Lives	TBC	Safety	TBC following gap analysis
Healthy pregnancy schemes	TBC	Safety	Multi-agency working to promote healthy living during pregnancy and reduce negative outcomes i.e. weight management, smoking cessation, wellbeing
Post Birth contraception	TBC	Safety	To support women vulnerable of becoming pregnant shortly after birth by offering early contraception advice and implants

5.3 **Strategic and Clinical Leadership**

The Local Maternity System Board (LMSB) was establish in 2017. It is the strategic vehicle for maternity transformation and quality improvement, with key stakeholders represented. It seeks assurance that the national transformation programme is delivered locally, and to the quality standard that is required for our residents. The LMSB oversees the programme but will also gain its assurance from the Alliances to ensure service developments are implemented, and embedded within local services. Each Alliance has an executive lead and senior responsible officer for the programme.

The programme is clinically led. The Chief Nurse (Suffolk) is SRO. A full time senior midwife and obstetrician (1 day per week) were appointed in October 2018. They are responsible for moving the transformation agenda forward, setting the ambitions for maternity services, and assisting the system learning and development. A part-time programme manager (0.6 wte) supports the clinical leads and SRO to manage the transformation programme, and provide assurance of accountable organisations.

The three Alliances will have maternity forums, where local performance, learning, and transformation delivery will be addressed for the population served. The LMS Board will set the vision and overarching transformation programme. The Alliances will implement and embed the programme, and need a forum to resolve local issues, and ensure the correct allocation of resources according to their population's needs. The Alliances will therefore develop local maternity delivery plans, providing assurance of delivery to the LMSB, and to their individual Alliance governance frameworks.

This work has begun through the creation of a 'Healthy Pregnancy Plan for Suffolk and North East Essex' with the support of Public Health Suffolk. The plan's priorities are to:

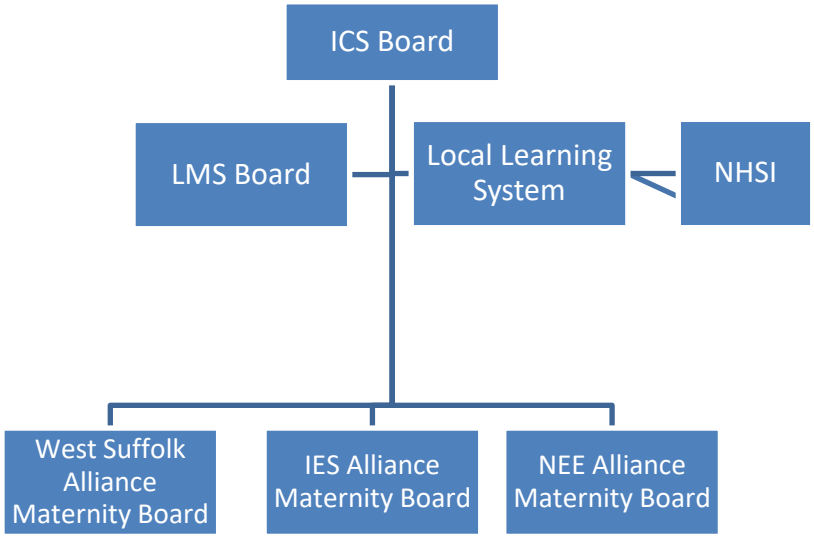
- Support good maternal and paternal health
- Promote best start in life for babies
- Increase safe deliveries and good birth weight
- Prevent adverse health factors in pregnancy

5.4 **Quality and Continuous Improvement Leadership**

In line with the national neonatal Health and Safety Collaborative programme a Local Learning System (LLS) forum has been developed. The group reviews maternity and neonatal care, enabling learning to be shared across the system, and quality improvements to be made.

All programmes of work have a continuous improvement methodology incorporated. MVP groups are championing the review of initiatives, and working their respective Alliance colleagues to address any changes that are required.
A Serious Incident/near miss group has also been established, led by the Obstetrics clinical lead. All providers discuss Serious Incident/near misses, and share the learning and actions they have taken as a result. This will enable good practice to be adopted across the whole LMS, and enable consistent care and quality levels to be achieved.

Maternity Transformation Programme Assurance Framework



5.5 **Evaluation Framework for Maternity Transformation Programme**

NHSE are in the process of developing an evaluation framework/set of core KPI's for the maternity programme. In the meantime, the LMS has put an evaluation framework in place, which is reviewed by the Board on a monthly basis. It is focussed on areas such as:

- Family & Friends testing
- Complaints and Serious Incidents
- Number of babies requiring therapeutic cooling
- Smoking rates in mothers
- % normal vaginal deliveries vs % c-sections
- No. of stillbirths
- No. of neonatal and maternal deaths

The clinical leads and public health will develop the current evaluation framework to ensure it is robust, and provides sufficient information to support the continuous improvement of services, as well as the overarching maternity transformation programme. The local evaluation framework will directly link into the regional reporting framework to NHS England.

6. Conclusion

6.1 Robust clinical leadership and programme governance arrangements are in place, work streams are embedded and delivering, and the financial plan has been submitted for approval from NHSE. However, extensive work is still required to deliver the remaining milestones/service developments. This will require investment from the entire system and is therefore a significant risk.