

Transformational Plan for Maternity Services February 2018



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1. Introduction

The outcome of the Department of Health National Review on Maternity Services 2016 (Better Births) has provided us with the opportunity to refresh and update our current model within the Sustainability and Transformation Partnership (STP) and articulate the direction of travel for the next five years and beyond for maternity and neonatal services across Leicester, Leicestershire and Rutland. The strategy will be a description of how the Local Maternity System (LMS) aims to continue to transform local services and implement national initiatives in the context of Better Births.

Our local partnership has already seen the implementation of a local maternity dashboard, along with the development of partnership pathways and strategies to support areas such as transition to parenthood, infant feeding and reducing infant mortality. It also has an existing Maternity Services Liaison Committee which will support us in the development of local Maternity Voices Partnerships. This provides us with a good foundation on which we can continue to build when looking at continuing our transformation in line with Better Births.

In addition, there has been a national neonatal review undertaken by the Clinical Reference Group (CRG). We are still awaiting the recommendations from this report. However, the CRG have released some preliminary guidance for inclusion of neonatal priorities within LMS plans and these have been included in our plan. The Quality Surveillance Team (QST) undertook a national peer review of neonatal services in 2017 and the results of this have also been included in our strategy.

This plan has been through several stages of review and has been agreed by our STP processes. This has included stakeholder events held to help develop the plan. Feedback and agreement for the model has been sought from a range of key forums including the Maternity Services Liaison Committee, GP forums, the STP PPI forum and all three CCGs. It has also been scrutinised by the STP Clinical Senate and the Regional Senate.

The next stage of engagement will be in line with STP process and will include being presented at overview and scrutiny committees as well as a formula engagement and communication process. We are currently developing a public facing version of the plan and intend a public launch in line with STP processes.

Users will be able to say the following about maternity and neonatal services:

- I will have choice on where I receive my antenatal and postnatal care and if appropriate I will be offered a Personal Health Budget
- I have a range of clinically appropriate options available to me in relation to where I give birth, e.g. at home, in a midwife-led unit or obstetric unit. I am aware that if I want an epidural I will need to go to the obstetric unit

- My care will be based around my individual needs and wishes and I will be given evidence-based information to support my decisions
- I can book with my midwife directly and am able to access services early (before 10 weeks of pregnancy), either through my GP practice or the hospital maternity website
- I will be offered a range of antenatal screening, including Down's Syndrome screening, detailed scans, other chromosomal abnormalities scan and detailed anomaly
- My partner and I are involved in my care and have the information to prepare for and manage our pregnancy/birth/parenthood, ensuring the best health outcomes for myself and my new-born
- I will have access to ParentCraft classes from midwives and other health professionals information about additional ParentCraft classes, depending on my needs, that may be provided locally
- I am able to access healthcare advice when needed in a setting close to home (GP Practice, Children's Centre or Community Centre)
- I know who to call if I am worried or want more information and can contact my named midwife / health visitor directly through a central call number
- My pregnancy will be monitored by the appropriate services and any problems will be picked up and dealt with quickly and to a high standard
- I will have most of my antenatal and postnatal care in a setting close to home as long as I am low risk and do not develop any complications
- If I do develop complications I will be referred to an obstetric unit for review and assessment but I will keep my named midwife throughout and still have midwifery care
- If my baby develops complications, e.g. is born unexpectedly premature, they will be cared for in the most appropriate care setting according to the care needs of the infant at that time, as close to home as possible

2. Scope

Our strategy describes how we will use established partnerships and integrated pathways within primary care, Local Authority and tertiary services to provide joined up personalised care. The LMS will provide the full range of antenatal, intrapartum and postnatal care within a pathway for women, their babies and their families. This includes scheduled and unscheduled care, outpatient and inpatient, community neonatal and home-based services. As part of delivering choice within the LMS, additional providers may be commissioned to deliver one or more of the core elements of the maternity pathway.

The scope will focus on these key elements:

- Improved general health and wellbeing and reduced infant mortality
- Antenatal care
- Midwifery-led care
- Joint obstetric and midwifery lead care
- Neonatal services focusing on the interface between maternity and neonatal
- Focus on postnatal care up to 6 weeks
- Perinatal mental health

3. Background

The majority of maternity care across Leicester, Leicestershire and Rutland (LLR), including community provision, is commissioned from University Hospitals of Leicester (UHL). The service is delivered from three key sites: Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and St Mary’s Birthing Centre in Melton Mowbray. The maternity services at the UHL NHS Trust undertook a total of 10,534 deliveries during the financial year of 2015/2016. These were divided between the LRI site and the LGH site, along with approximately 160 deliveries at St. Mary’s midwifery-led unit and approximately 160 home births in the community. At present, UHL continues to be the busiest maternity unit in the East Midlands with an average of 29 babies being born every day.

There were approximately 5,165 births commissioned from a range of cross-border providers including Peterborough, Kettering, Nottingham, Nuneaton and Burton in 2016/17. We will continue to work with our cross-border commissioners and providers to facilitate choice and to look at ways of further improving continuity for women who choose to have elements of their care across STP boundaries.

Neonatal Services are currently delivered across two sites; LRI and LGH. LGH has 12 cots to deliver special care. LRI has 30 cots, 12 of which are intensive care, 8 are high dependency and 10 are special care. In 2016, total admissions and readmissions were 1798, of which 1504 were inborn (out of 10,521 total births) and 100 outborn.

2016 BAPM 2011 and HRG Activity					
Level 1	Level 2	Level 3	Level 4	Level 5	Total Patient Days
2926	3334	8771	495	34	15,560

The service reached maximum capacity and the unit was running at 90-99% occupancy during January to September and >100% capacity during October to December in 2016.

Over the last five years, significant work has been undertaken locally in relation to improving and maintaining quality to ensure a safe and sustainable maternity service. This has resulted in significant investment in midwifery, neonatal and other obstetric services. However, services still face real challenges in relation to demographic issues, especially in the city and more generally in relation to capacity of the services to cope with increasing demand and complexity. Recent advances in maternity care and changes in the demographics of women having babies have both contributed to an increase in the complexity. Also, the current split-site working is causing difficulties for both neonatal and obstetric services and we know this is unsustainable.

The maternity facilities in UHL were designed to cater for approximately 8,500 deliveries per year, but deliveries now total approximately 10,534 per year. In 2010 the whole health community agreed, through the Next Stage Review, that the solution would be to have a single site maternity and neonatal service based at the LRI site, with the option of community birthing facilities. However, due to financial constraints at the time, an interim solution was adopted. The interim solution has been successful at sustaining the current provision, but progression to the single site option is imperative for the service to continue to transform and improve.

In 2012/13, all three LLR Clinical Commissioning Groups (CCGs) commissioned an independent review of maternity services following the recognition of a number of issues facing the service; including complex demographics and issues around capacity. The review found that maternity services were safe and providing good standards of care across LLR. However, the review also found that, despite the hospital redeploying staff and directing mothers to other labour wards when needed, services at LRI and LGH can become over-stretched during busy periods and recommended reviewing capacity. It also identifies four key priority recommendations:

- A review of the services in the Melton area including the services provided at St. Mary's Birthing Unit
- Revisiting plans for a new single site maternity and new-born hospital
- Reviewing obstetric neonatal and midwifery capacity
- Improving training and support for the midwives obstetrics and neonatal team

These recommendations were all taken into account when developing the Better Care Together (BCT) Programme. This has now been developed locally into the Sustainability and Transformation Partnership (STP). The aim is to provide high quality, safe maternity and neonatal services based on best practice and which are easily accessible. These services will offer a range of choice options and will be supported by the appropriate infrastructure across both primary and secondary care. There will also be sufficient capacity to care for babies requiring all levels of neonatal care from LLR and the surrounding neonatal network, whilst consolidating and further developing transitional care and outreach services to avoid unnecessary admissions and maternal/neonatal separations as well as facilitating early

discharge when appropriate. For this to be delivered, the midwifery, medical and nursing workforce needs to be developed across both maternity and neonatal services to ensure that adequate staff numbers and skill-mix are available at all times.

Within the LMS work stream, there is a focus on:

- Continue to promote a women centered culture ensuring women have personalised care and choice
- Improving outcomes through early access to antenatal screening by 10 weeks
- Reducing intrauterine deaths, still births and infant mortality
- Improving access and ensuring women are offered antenatal and new-born screening in a timely manner
- Providing high quality, safe maternity and neonatal services based on best practice which are easily accessible by consolidating all women's acute and neonatal services on a single site supported by appropriate infrastructure and a flexible, multi-disciplinary workforce that responds to changes in volume and complexity
- Ensuring babies requiring specialist neonatal care, e.g. surgical or cardiac, are cared for in the right cot at the right time, as near to home as possible
- Developing robust transfer pathways to facilitate in-utero transfer of premature and sick infants
- Integrating pathways across primary, secondary and tertiary services
- Improving integrated perinatal mental health pathways to ensure early identification and treatment to improve outcomes
- Reducing the number of babies separated from their mother by reducing avoidable term admissions through implementing the ATAIN recommendations and developing the transitional care services
- Ensuring adequate capacity, workforce and appropriate utilisation of regional neonatal transport services to support patient flows and guarantee that infants requiring specialist neonatal care (i.e. sick-term babies, premature babies, cardiac babies, and babies with neonatal surgical problems) are cared for in the right cot at the right time, as near to home as possible

Following the publication of Better Births (2016), the current strategy was reviewed. This has resulted in the production of a refreshed vision and the development of a transformational plan taking into account the work we have already undertaken, the recommendations in Better Births and the requirement to establish a Local Maternity System (LMS). There was a QST peer review visit in October 2017 which recommended neonatal facilities be located on a single site.

The LMS has reviewed the needs of the local population, utilising both the local Joint Strategic Needs Assessment (JSNA) and national data, including Public Health England and Embrace data, which clearly shows we have areas with high levels of need in Leicester City in relation to prematurity, infant mortality and high levels of congenital abnormalities compared to above-average outcomes in the East and the West of the county. We have used this information to support the development of our models of care, as it is clear that one size will not fit all. Below is a summary of the key findings from that analysis of local need.

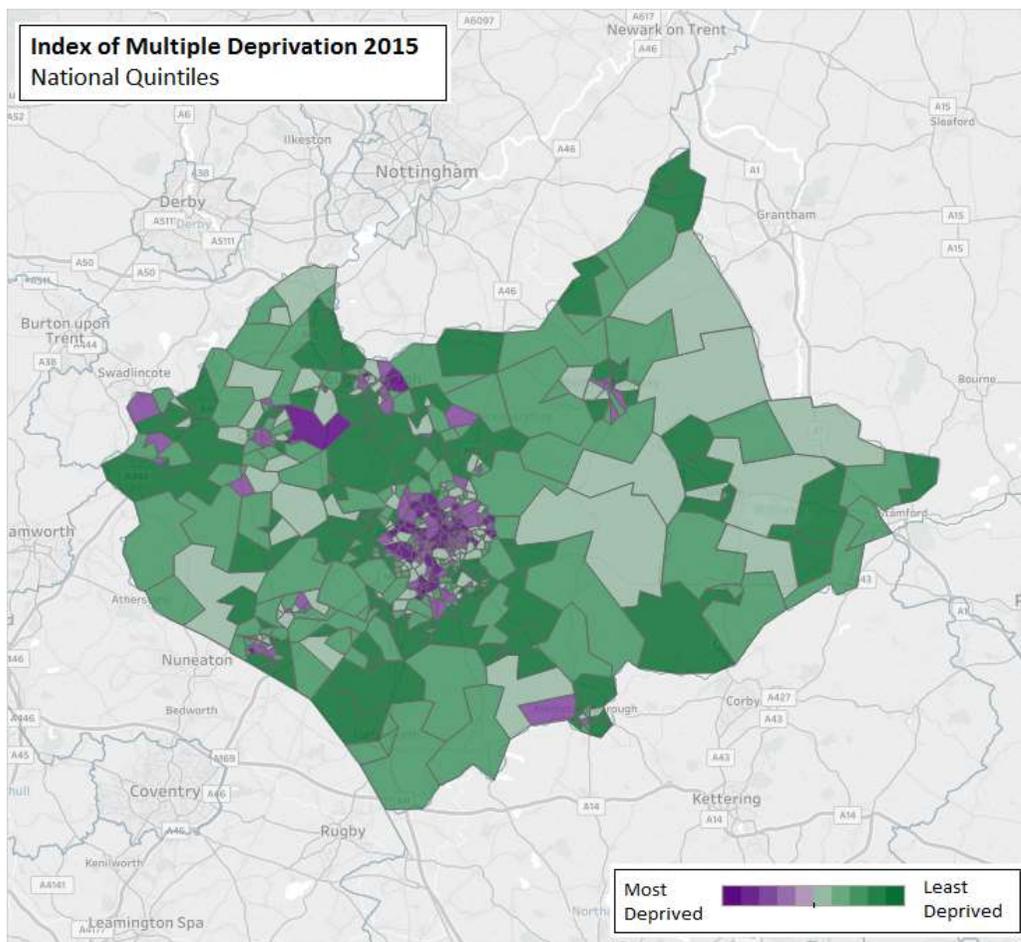
3.1. Demographics

Leicester, Leicestershire and Rutland (LLR) has a population of over 1,000,000 residents - of which over 200,000 residents are women aged 15-44 years. The population of LLR is currently growing and by 2039 the total population is predicted to reach 1,231,900 people, representing growth of 18%. However, the population is not growing uniformly across the different age bands. In the next 25 years, the population is predicted to grow as follows:

- A 8% increase in children aged 0-4 years (63,800 people to 68,800)
- A 17% increase in children and young people aged 0-24 years (1,379,700 people to 1,608,200)
- A 6% increase in the working age population aged 25-64 (from 529,300 people to 563,400)
- A 50% increase in people aged 65-84 year olds (from 154,900 people to 232,600)

Furthermore, by 2039 the number of women in their reproductive years (aged 15-44 years) is predicted to increase by 8% to reach 222,000 in 2039. The projected number of complex births is also expected to increase.

Throughout Leicester, Leicestershire and Rutland, the ethnic mix of residents varies considerably between areas. In Leicester City, 49.5% of the population are from Black and Minority Ethnic (BME) groups, whereas in Leicestershire and Rutland, BME residents comprise of 8.6% and 2.9% of the population respectively. In Leicester City, 27.5% of all residents have a main language other than English. In Leicestershire and Rutland, this percentage falls to only 3.8% and 1.8% of the total population. The figures below shows that the level of deprivation varies throughout LLR:



- 44% of the population of Leicester City (150,461 people) live in areas categorised within the most deprived 20% of areas in the country, compared with 2% of the population of Leicestershire (12,546 people)
- 33% of the Leicester City population and 11% of the Leicestershire population live in the second quintile of deprivation (in the most deprived 20-40% of areas in England), accounting for over 188,000 people throughout Leicester City and Leicestershire
- Almost half (45%) of the Rutland population (17,440 people) and over a third (36%) of the Leicestershire population (244,000) live in the least deprived 20% of areas in the country. Only 1% of the population (4,475 people) in Leicester City live in the most affluent areas of the country

Leicester City has significantly worse rates of life expectancy in both males and females compared to the national average. The percentages of children from low income families or families in fuel poverty and unemployment rates are all significantly worse than the national rate. Leicester City has a significantly higher rate of lone parent families, fertility and teenage conceptions, and 50.2% are born outside of the United Kingdom (many whose first language is not English), compared with 12.9% in Leicestershire and Rutland. Leicestershire and Rutland are statistically similar or lower than the national average for these indicators. Throughout LLR, the rate of infant mortality is higher, but not significantly, than the national average. The number of live births in LLR is predicted to reduce but the complexity is predicted to increase. Not all women living within the LLR boundaries deliver at the main provider units; a significant number of women, over 3000, choose to deliver in one of the provider trusts bordering LLR.

3.2. Births in Leicester, Leicestershire and Rutland

In 2015, there were 12,458 births to women living in Leicester, Leicestershire and Rutland. The total number of births have increased year on year for the past two years from 12,036 in 2013 and 12,394 in 2014. In 2015/16 there was a reduction in births to 10,534, however this is predicted to increase in number and complexity. Based on the information we have received from Public Health colleagues, we have estimated the following trend in births in LLR year-on-year:

Predicted LMS Births						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Births at UHL	10,534	10,745	10,960	11,179	11,403	11,631
Births in LLR	12,458	12,707	12,482	12,483	12,158	12,482

The age of mothers at birth varies throughout LLR. Leicester City has a significantly worse rate of teenage conceptions compared to the national average, whereas Leicestershire and Rutland have a significantly better rate. Furthermore, Rutland has a higher percentage of mothers giving birth who are aged 40 or over compared to the national average.

The General Fertility Rate (GFR), defined as the number of live births per 1,000 women aged 15-44, for Leicester City is higher than the national average, whereas in Leicestershire and Rutland the GFR is lower. The GFR in Leicester City shows a downward trend since 2010, whereas the GFR in Rutland has seen a year on year increase from 2011 to 2014. Leicestershire has the lowest GFR out of all areas in LLR.

The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the year in examination. In 2015, both Rutland (2.1) and Leicester City (1.9) have a TFR higher than the national rate (1.8). Leicestershire has a TRF lower than the national average (1.8).

There are a number of clinical drivers for change, including:

- Complex picture of health needs across LMS with pockets of high levels of need focused in the City
- Projected increase in number of complexity of births
- Leicester City being the 20th most deprived area in England
- High proportion of the population from BME groups and mothers who first language is not English
- High rates of low birth weight babies

- High rates of infant mortality which may be linked to the population profile
- High rates of teenage pregnancy
- Average or above average outcomes in East and West of Country

3.3. Financial Challenges

The final version of the local STP is currently still in draft format awaiting sign-off. Below a high-level summary of where we are, however it must be noted that the final figures may change. We have also attached the November 2016 draft of the STP within the action plan.

The financial challenge facing the NHS nationally over the next five years are well recognised, with 2018/19 set to be the most pressurised year; where the NHS is set to have negative per person NHS funding growth. The Leicester, Leicestershire and Rutland system will spend £2.121 billion on health and social care in 2016/17. If nothing is done, the system deficit is estimated to be £384m; health £330m and social care £54m by 2021/22.

The aim of our local STP is to save £366m across our five priority areas listed below:

- New models of care focused on prevention, moderating demand growth
- Service configuration to ensure clinical and financial sustainability
- Redesigned pathways to deliver improved outcomes for patients and deliver core access and quality standards
- Operational efficiencies
- Getting the enablers right

The maternity transformational plan supports the delivery of all five priority areas and is a key enabler to service configuration to ensure clinical and financial sustainability. To deliver these savings, LLR has requested investment of £66m from the national Sustainability and Transformation Fund during this time period. The system will return to financial balance by 2023-24 when the additional cost of operating on three acute sites is removed. To realise our transformation plans, the system will require £398m capital, including capital raised from alternative sources such as PF2 and funding from some investments from disposal proceeds.

The LMS plan requires a significant element of the STP capital to support the development of the new Women's Hospital which will be the hub for the models of care. Implementing the new models will facilitate a lean efficient organisation which will intern deliver revenue savings as part of the 3 to 2 local configuration plans well as a sustainability of the services in-line with current investments. Implementing our plans for continuity will also require a new way of commissioning and we are working with our finance and contracting teams to look at an outcome-based commissioning approach and how this can be implemented alongside the current tariff arrangements. We are also

looking to the Early Adopters and national team to provide support and guidance in relation to this. This is especially important when we move to phases two and three of our plans, which will see midwives working in a mix of case holding and small teams and may require the development of a business case for consideration by the SLT. The finance plan below provides an estimate of the cost of our proposed core model and this is in line with current financial plans.

3.3.1. Summary of Projected Figures

Antenatal	2017/18		2018/19		2019/20		2020/21	
Provider	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
UHL	12,329	£18,217,867	12,575	£18,953,869	12,827	£19,719,605	13,083	£20,516,277
Out of County	2,507	£832,966	2,557	£866,618	2,608	£901,629	2,660	£938,055
Total	14,835	£19,050,833	15,132	£19,820,486	15,434	£20,621,234	15,743	£21,454,332
Postnatal	2017/18		2018/19		2019/20		2020/21	
Provider	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
UHL	11,484	£3,240,649	11,714	£3,371,571	11,948	£3,507,783	12,187	£3,649,497
Out of County	531	£95,389	542	£99,242	552	£103,252	564	£107,423
Total	12,015	£3,336,038	12,255	£3,470,814	12,500	£3,611,035	12,750	£3,756,920
Births	2017/18		2018/19		2019/20		2020/21	
Provider	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
UHL	9,483	£26,983,012	9,673	£28,073,126	9,866	£29,207,280	10,063	£30,387,254
Out of County	4,707	£5,985,898	4,801	£6,227,728	4,897	£6,479,328	4,995	£6,741,093
Total	14,190	£32,968,910	14,474	£34,300,854	14,763	£35,686,608	15,059	£37,128,347
Home Births	2017/18		2018/19		2019/20		2020/21	
Provider	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
UHL	258	£489,672	263	£509,454	268	£530,036	274	£551,450
Out of County	95	£44,043	96	£45,822	98	£47,673	100	£49,599
Total	353	£533,714	360	£555,277	367	£577,710	374	£601,049
Totals	2017/18		2018/19		2019/20		2020/21	
Provider	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
UHL	33,554	£48,931,199	34,225	50,908,020	34,909	52,964,704	35,607	55,104,478
Out of County	7,839	6,958,295	7,996	7,239,410	8,156	7,531,883	8,319	7,836,171
Total	41,393	£55,889,495	42,220	£58,147,430	43,065	£60,496,587	£43,926	£62,940,649

Assumptions

The figures for 2017/18 are based on actual YTD figures for the first 9 months of the year, grossed up to 12 months.

Growth of 2% in activity has been assumed year on year to arrive at activity levels for 2018/19, 2019/20 and 2020/21.

Price increases of 2% has been assumed year on year.

The Out of County figures comprise Kettering, North West Anglia, Derby, University Hospitals of Coventry and Warwickshire, Burton and Nottingham.

The capital cost for the new women's unit is estimated at between £84.4m and £94m and is part of the overarching £398m capital funding required.

The above figures show forecast activity and costs for antenatal, postnatal, births and home births across the three Leicestershire CCGs for the four financial years from 2017/18 to 2020/21.

3.4. Capacity and Capability of Neonatal services

(CRG Neonatal Critical Care Review)

Neonatal care is a highly intensive environment in which nurses and doctors provide continuous support for very sick babies and their families 24 hours a day. Since 2013 services have been managed within Operational Delivery Networks. There has been a recent review of neonatal services across England and Wales since it is recognised that there are challenges in the delivery of neonatal care due to appropriate capacity, staffing difficulties and uncertainty over the best model of care, particularly in the immediate perinatal period. The national maternity review findings outlined how maternity services cannot be considered in isolation and are inextricably linked to neonatal services, which are essential in delivering optimal outcomes for babies. The national maternity review highlighted a number of concerns linked to neonatal medical and nursing staff numbers, staff training, the provision of support staff and cot capacity, safety and sustainability.

The drivers for change across neonatal intensive care services are linked to a combination of the need to start neonatal intensive care in the best place possible to promote survival and decrease morbidity whilst delivering care for that family as close to home as possible. The challenges for neonatal services relate to a lack of clarity regarding the best models of care, capacity and patient throughput, workforce and safety issues, and the utilisation of transport services to support patient flows.

The CRG will be publishing the report of the review later this year but have given some guidance regarding neonatal themes to be included within the LMS plan as follows:

- Mortality
- Capacity
- Workforce planning
- Term admissions and ATAIN
- Transport and transfer
- Screening women at high risk of premature delivery and the optimisation of prophylactic medicine to optimise neonatal outcomes
- Reduction in the number of babies separated from their mothers by reducing unacceptable variation in practice for term admissions and access to transitional care facilities

3.5. Workforce

The current workforce picture is mixed. It is very positive in terms of midwifery numbers, for example we currently have a waiting list for staff wanting to work in the local LMS. We also already have a midwifery structure which includes maternity support worker roles, use of nurses in theatres and children's nurses and nursery nurses in transitional care. We are currently developing our models of care around continuity, looking at a mix of both case holding and team working. Although midwifery recruitment is positive, a recent review using the Birthrate Plus equity tool identified that we need more midwives due to the complexity of cases mix. We are developing a business case to request additional capacity to address this. We also recognise that to deliver continuity of care, we may need additional midwifery resources and we are currently looking at the workforce impact, the cost implications and the practicality of recruiting these additional midwives on top of ensuring we maintain current capacity despite attrition due to retirement.

Our key workforce challenges relates to some significant medical staffing issues for both maternity and neonates at middle grade and junior doctor level, which is exacerbated by being split across more than one site. Work on the new models of care will help to address this but in the short term it is providing significant challenges and a lack of obstetric sonographers and neonates nursing vacancies are adding to the pressures. We are working with HEEM and local universities to look at the number of training places and ways to address the shortage, the national workforce review findings will also inform the work planned and undertaken.

Locally there is a strong culture of services being woman-centred, however it is acknowledged that some staff will have concerns about the proposed new model and if we are to be successful in implementing our local LMS plan this plan needs to be believed in and understood by staff on the ground. To support this we have appointed a clinical midwife as part of the PMO and we are planning to identify Better Birth 'champions' across the service. We also plan to establish a newsletter and forums where key members of the pathway, e.g. midwives and health visitors, can share their views on the plan including what is working and what needs to change.

It is also important that we continue to develop a culture where staff are nurtured and cared for, where the stresses they face on a daily basis are understood and where they as individuals are supported. We are working with the Royal Collage of Midwives and Health and Safety rep to imbed the 'Caring for You' campaign.

Workforce review and development is being lead through the STP workforce steering group and the women's models of care are supporting this work, exploring the opportunity to work differently and to provide safer and more sustainable long-term workforce solutions, particularly in areas where there are current workforce shortages. These require further development, including the following areas:

- **Innovative work practices** – New roles (e.g. Physician Associates, Advanced Clinical Practitioners, Midwifery/Nurse Associates, Staff Grade Doctors and Extended Scope Therapeutic Practitioners) and new ways of working.
- **Student and newly qualified experience** - Preceptorship – Maintain and further develop the preceptorship midwife role
- **Training and future supply** – Working closely with DMU in providing two midwifery cohorts a year and a positive training experience to enhance future recruitment and retention. Pending approval from the NMC, Leicester University have developed a

MSc in Midwifery with Leadership over four years. Along with four year courses in Adult with Mental Health and Child with Mental Health, they could all start from September 2018.

- **Developing a woman-centred culture across all pathways** – We are establishing Better Births champions across the organisations that can support implementations of Better Births and provide a sense of ownership and engagement. We also plan to have a link midwife as part of the PMO who can support engagement of front line staff.
- **Developing models of care to deliver continuity** – Looking at both cases holding and team midwifery models, along with current gaps in capacity based on Birthrate plus, the use of maternity support works and other roles without diluting the skills mix too much so it impacts on quality. We are awaiting the outcome of the pilot sites to help inform our future models and working practices, supported by exploring commissioning for outcomes, not on tariff.
- **Development of single site model** – from a workforce perspective the development of one major site delivering women’s services is a considerable benefit. Even with the option of a midwife led unit, the efficiency and flexibility from a single site model for medical staff alone reduces the risks of gaps and therefore helps control premium spend. Rostering and out-of-hours cover is more sustainable on a single site and should enhance the training experience for junior doctors. A new environment should also enhance recruitment and support retention. This does need to be set against the risk of higher turnover for staff that may be affected by changes to the sites where care is delivered.
- **Digital technology** – One way we are looking at reducing pressure on the limited workforce and providing individualised care close to home is by looking at the use of digital technology as well as working towards having electronic personal care records to facilitate the ability to share information with other professionals, allowing the woman and her partner to be able to add information to make it truly individual and personalised. We are also exploring virtual clinics and digital monitoring of women with conditions such as diabetes and hypertension; where women can self-monitor and send information in for review, reducing the number of times a woman has to visit specialist clinics.
- **Development of a healthy workforce** – We are imbedding the ‘Caring for You’ campaign, looking at themes from staff surveys, establishing focus groups to improve communications and providing emotional health and wellbeing training for staff.

3.6. Estates

There are three key estates issues which have influenced the proposed models of care:

3.6.1. Acute Maternity Facilities

Maternity facilities in UHL were designed to cater for approximately 8,500 deliveries per year, but deliveries now total approximately 10,534 per year. In 2010 the whole health community agreed, through the Next Stage Review that the current situation was unsustainable in the longer term and recommended co-location onto a single site as the preferred long term clinical model. The principal reasons for this were the recognition of the current capacity issues and the need to modernise the current environments but the key issue was the inability to maintain two large acute maternity services in LLR in the long term as they both require resources (staff, estate and acute support

facilities) that will not be available. Already there are times when the safety of care on either of the two sites is compromised by the availability of this resource, particularly in neonatology and obstetrics, and whilst this is managed effectively at present it is not considered sustainable for the long-term.

3.6.2. Standalone Midwife-Led Facilities

The other estates issue is in relation to the current standalone maternity unit at St Marys. Various reviews all identified that the standalone birthing centre at St Mary's in Melton Mowbray is not accessible for the majority of women in LLR and is underutilised; on average there is only one birth taking place every 2.5 days. This underutilisation makes the service no longer viable. This reflects the choice of birthplace made by women in LLR as a whole and is likely to be related to concerns about proximity to medical support for some mothers but also accessibility to Melton for those who might choose a standalone birth centre option. Many of these women will be currently choosing to have their baby in the alongside Midwifery Birthing Unit at the LRI and the LGH. This underutilisation of St Marys is despite significant effort to promote the facility and as a result it is proposed to close this centre. However, it is recognised that many women may prefer to choose to have their baby in a community based standalone Midwifery Birth Unit and there should be consultation on offering this as an option on a site which provides the best equity of access for the women of LLR. The proposal therefore is to consult on an option to provide a standalone midwifery led unit at the Leicester General Hospital site with a view to maintaining this for the long-term if there is sufficient utilisation to ensure its sustainability. This proposal is based on stakeholder engagement sessions which involved detailed evaluation and a one-off event with midwives, patient representatives and interested stakeholder groups to discuss national guidance, constraints to the current service, how the service currently works and what they might look like in the future.

3.6.3. Community Facilities (Community Hub)

Currently midwives deliver antenatal and postnatal care from a range of community facilities including GPs practices, childrens centres and community hospital as well as other community facilities. This approach allows the midwife to deliver care close to home and to liaise with other members of the health care team to ensure the woman and her family receives integrated care from a range of health professionals. This is very important in the city and other areas where we have vulnerable and high risk groups, as it facilitates access and allows us to deliver different types of care dependant on local need and which is acceptable to the woman and her community. For example, in the city we run special parenting classes from culturally accepted facilities and some religious buildings. Currently there is an increased pressure on these facilities, both in terms of space and financially. Our model required the ability to continue to work in this way, with the community midwife being the care co-ordinator for the woman and her family for all other services. We are working with our primary care colleagues to ensure midwives are welcomed into these facilities and given access to IT to support them to undertake this key role within the model of care.

3.7. Summary of Services

3.7.1. Maternity

UHL provides a full range of maternity services for approximately 11,000 women, the majority who live in the Leicester City, Leicestershire and Rutland (LLR) area. Services are provided on three sites, the Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and St Mary's Birthing Unit. In addition, 10 teams of Community Midwives and Maternity Care Assistants (MCA) deliver antenatal and postnatal care in women's homes, clinics and children's centres across LLR parent education is provided in the community and women have the option of parent education within the hospital in evenings and weekends. UHL has a 24 hour service as well as supporting a Homebirth Service which supports around 1.5% of the maternity population, despite efforts to increase home birth rates this level has not changed with women preferring to use the low risk alongside birth centre option. Therefore the development of a home birth team that is to be launched in September 2017 has taken place in the hope this may improve the homebirth rate. UHL is also one of the lead neonatal units in the east midlands neonatal network with a level 1 unit at the LGH and a level 3 at the LRI. UHL also provides two alongside low risk birthing units through which an average of 22% of the women deliver their baby's, a variety of specialist antenatal clinics for women with complications and a fetal medicine service through which referrals are received from other Trusts in the region as well as supporting a Homebirth Service.

3.7.2. Neonatal

University Hospitals of Leicester Neonatal Service is a Lead Perinatal Centre and is one of the largest units in the country, delivering a full range of care to all babies born within and beyond the Central New-born Network. The Leicester Neonatal service is split across 2 sites with a total of 12 ITU cots, 8 HDU cots and 22 Special care cots.

In 2016, total admissions and readmissions were 1798, of which 1504 were inborn (out of 10,521 total births) and 100 outborns. The following is the 2016 BAPM 2011 and HRG activity; Total patient days – 15,160; Level 1 – 2,926; Level 2 – 3,334; Level 3 – 8,771; Level 4 - 495 and Level 5 - 34. The service reached maximum capacity and the unit was running at 90-99% occupancy during January to September and >100% capacity during October to December in 2016.

Leicester neonatal service has continued to flourish throughout 2016 with clear focus on delivering clinical effectiveness, patient safety, family friendly care and improving parents' experiences. The neonatal service is committed to delivering the standards highlighted in the Department for Health Toolkit for High Quality Neonatal Services (2009), BAPM and NICE.

UHL is the lead neonatal intensive care centre and regional neonatal surgical centre for the Central New-born Network. It provides tertiary neonatal services for the following hospitals; Northampton General Hospital; Kettering General Hospital and Queens Hospital, Burton-on-Trent. There is also flow for neonatal surgery from the West Midlands from the following hospitals along agreed network pathways; University Hospitals of Coventry and Warwickshire; Warwick and George Eliot, Nuneaton.

Maintaining adequate patient flow is dependent on robust neonatal transport mechanisms. UHL hosts the regional neonatal transport service. This is commissioned to deliver transport to the 14 units of the current Central New-born Network and Trent Perinatal Network footprint (LRI, LGH, UHCW, GEH, Warwick, NGH, KGH, Burton, Derby, Nottingham City, QMC, Kingsmill Hospital, Lincoln County, and

Pilgrim Boston). CenTre is a 24 hour, 7 day a week transport service and undertakes around 1600 transfers (both acute and repatriations) annually and is one of the busiest neonatal transport services in the UK. There are two acute day teams and one night team. These teams are dispatched from both NUH and UHL. Consultant cover is shared between the three tertiary NICUs in the patch (UHCW, UHL, and NUH). It is important to note that not all women living within LLR deliver at the main provider units. A significant number of women, over 3000, choose to deliver in one of the provider trusts bordering LLR.

3.7.3. Health Promotion and Prevention

The Health profile across Leicester Leicestershire and Rutland is a varied and complex picture with 44% of the population of Leicester City (150,461 people) categorised as living in the most deprived areas, 36% of the Leicestershire population (244,000) living in the least deprived areas, and 1% of the population (4,475 people) in Leicester City living in the most affluent areas of the country. This requires our prevention and health promotion strategy to be flexible and focused. There is a strong focus on prevention across the Local Maternity System in Leicester, Leicestershire and Rutland (LLR). Although Leicester City, Leicestershire and Rutland Public Health teams take the lead on prevention, the prevention work is delivered using a multi-agency partnership working approach. The aim is to embed a culture whereby the prevention work stream is seen as 'everyone's business' and in ensuring every contact counts.

Pregnancy and birth provide the opportunity to support the woman and her family to have a healthy lifestyle and improved outcomes. This is often the first time many women have come into contact with health professionals and, by using the personalised care plan, the multi-disciplinary team can provide information on the importance of a healthy lifestyle for her and her unborn baby. Advice and signposting can be provided where necessary to address key health markers, such as exercise, diet, smoking, drugs, alcohol, immunisations and screening. This is brought together under the overarching Health and Wellbeing Strategy and, although this strategy has a wide breadth, there are two main elements that link with the LMS; the LLR Infant Mortality Strategy and Action Plan and LLR Infant Feeding Strategy and Action Plan. We have also locally commissioned a JSNA in relation to maternity obesity to support us to look at local need and shape prevention pathways.

3.7.4. Infant Mortality

Infant Mortality is tackled by a multi-agency partnership strategy group comprising of all of the key stakeholders, such as maternity services, Local Authority Early Help and Children Centre Programmes, Healthy Together 0-19 Healthy Child Programme services, the Lullaby Trust, Stillbirth and Neonatal Death (SANDS), NHSE, Stop Smoking Service, Child Death Overview Panel, Public Health and CCGs. We are also working together as a partnership to help deliver the national ambition to implement the saving babies lives care bundle to reduce stillbirths and neonatal deaths by 20% and 50% by 2025. The following factors are addressed through the strategy and details can be found within the attached action plan:

- **Factors related to mother:** maternal age, smoking in pregnancy, smoking in homes and cars ('Step Right Out'), maternal obesity, maternal education and attainment, domestic violence and maternal ethnicity

- **Factors relating to the infant:** low birth weight, breastfeeding, infection, congenital abnormalities, reduce awareness of reduced fetal movements
- **Factors relating to practice;** improved risk assessment and surveillance for fetal growth restriction Effective fetal monitoring during labour,
- **Wider determinants:** poverty and deprivation, housing and overcrowding, sudden infant death syndrome

Outcomes to be achieved have been identified for each of these factors, and wider determinants, within the Action Plan.

3.7.5. Infant Feeding

Infant feeding, including healthy start vitamins, is also tackled by a multi-agency partnership strategy group and infant feeding network comprising of commissioners, providers, the National Childbirth Trust, peer supported infant feeding coordinators from Maternity services, the 0-19 Healthy Child Programme and midwives including a specialist consultant midwife from Public Health.

The strategy's objectives include:

- Achieve and maintain full UNICEF UK Baby Friendly Initiative (BFI) accreditation for Women and Children's Services in the acute and community settings
- Develop LLR's breastfeeding support network to offer universal support to breastfeeding mothers
- Implement workforce training and development in all maternity and 'early years' settings to increase knowledge of infant feeding
- Develop a cross-organisational infant feeding pathway that includes pre-conception, pregnancy and children aged 0 to 5 years to promote optimum nutrition
- Engage and communicate the benefits of breastfeeding and infant nutrition to all populations in LLR
- Create a culture where breastfeeding becomes the easier choice and use our collective influence to ensure this happens

3.7.6. Healthy Together 0-19 Programme

Leicestershire Partnership NHS Trust (LPT) has been commissioned by three respective Local Authorities (Leicester City Council, Leicestershire County Council and Rutland County Council) to deliver Healthy Together across Leicester, Leicestershire and Rutland. This has been developed in partnership with key stakeholders including maternity services and commissioners. In Leicestershire and Rutland this is a 5 year commissioning programme which began on 1st April 2017, and in the City it is a 4 year programme beginning 1st July 2017. Healthy Together is the Public Health offer for children aged 0-19 and it includes the Health Visiting function. This work is delivered via a partnership between health visiting, maternity services and primary care, and has been especially effective in relation to multi-agency decision making, assessment and planning interventions (such as the action plan for Infant Mortality and infant feeding), along with the following key contacts:

- Mandatory Antenatal visit at 27+ weeks

- Mandatory New Birth visit at 10-14 days
- Mandatory 6-8 week check
- Optional 4 month check

There is also a joint focus around transition to parenthood and the early weeks, maternal mental health, breastfeeding (initiation and duration), healthy weight, healthy nutrition and physical activity, managing minor illness and reducing accidents, healthy 2-5 year olds (including emotional, physical and speech development) and support to be ready for school. In addition, a local priority area has been identified as oral health. This work is delivered via partnership forums such as the maternity services liaison committee, where the majority of the integrated pathway work takes place, along with the infant mortality strategy group and the infant feeding partnership.

Running alongside this work is 'Chat Health', a text service that can be used by families to get general advice and raise questions to which a reply will be received within 24 hours. Families can access up to 4 sessions of support on a range of issues such as sleep, breastfeeding and family support and the most vulnerable mothers are offered the Early Start programme, where they receive intensive Health Visiting support from early pregnancy until the child is 2 years old. All of this is offered in discussion and liaison with maternity services. In addition, mothers who are struggling to breast feed are offered feeding support from peer supporters trained and linked into the maternity hospital. In the City and Counties, 'Bumps to Babies' is the universal antenatal programme open to all mothers-to-be and their partners. It is a 6 week course in the City and a 4 week course in Leicestershire & Rutland, delivered from Children's Centres by Children Centre staff, Midwives and Health Visitors.

3.7.7. Perinatal Mental Health Service

Perinatal mental health disorders are those that complicate pregnancy and the postpartum year. They include both conditions with their onset at this time and pre-existing conditions that may relapse or recur in pregnancy or the postpartum year.

Psychiatric disorder is a leading cause of maternal death. It has caused 12-15% of all maternal deaths in pregnancy and six months postpartum since 1997. Evidence shows that the treatment of serious mental illness in pregnancy and following childbirth by Specialised Perinatal Mental Health Services (In-Patient Mother and Baby Units and / or Perinatal Community Psychiatric Teams) results in improved mental health outcomes for women, their children and wider family, compared to standard psychiatric care.

The epidemiology of postpartum psychiatric disorders and their service uptake is well established. 2 per 1000 women delivered will suffer from a postpartum psychosis and are admitted to a Psychiatric Unit. A further 2 per 1000 delivered women will be admitted suffering from other serious / complex disorders. All of these require Specialised Mother and Baby Units, 3% of maternities will be referred to Secondary Psychiatric Services, and 10 to 15% of all delivered women will suffer from mild to moderate postnatal depression, the majority of whom will be cared for in Primary Care.

For perinatal mental health, the focus is on improving the treatment and management of pregnant and postpartum mentally ill women by maternity, psychiatric and primary care services, as set out in the following guidelines

We have a local Perinatal Mental Health Service which provides assessment, intensive support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services. They also assist in the detection and proactive management of women who are at risk of developing a serious perinatal postnatal mental illness and provide advice and assistance to primary care, maternity and psychiatric services on the treatment and management of serious perinatal mental illness. We are currently reviewing this provision to improve its inter-agency working and ability to increase capacity to meet more women's needs in line with national ambition.

4. Local Maternity Systems (LMS) Governance Structure

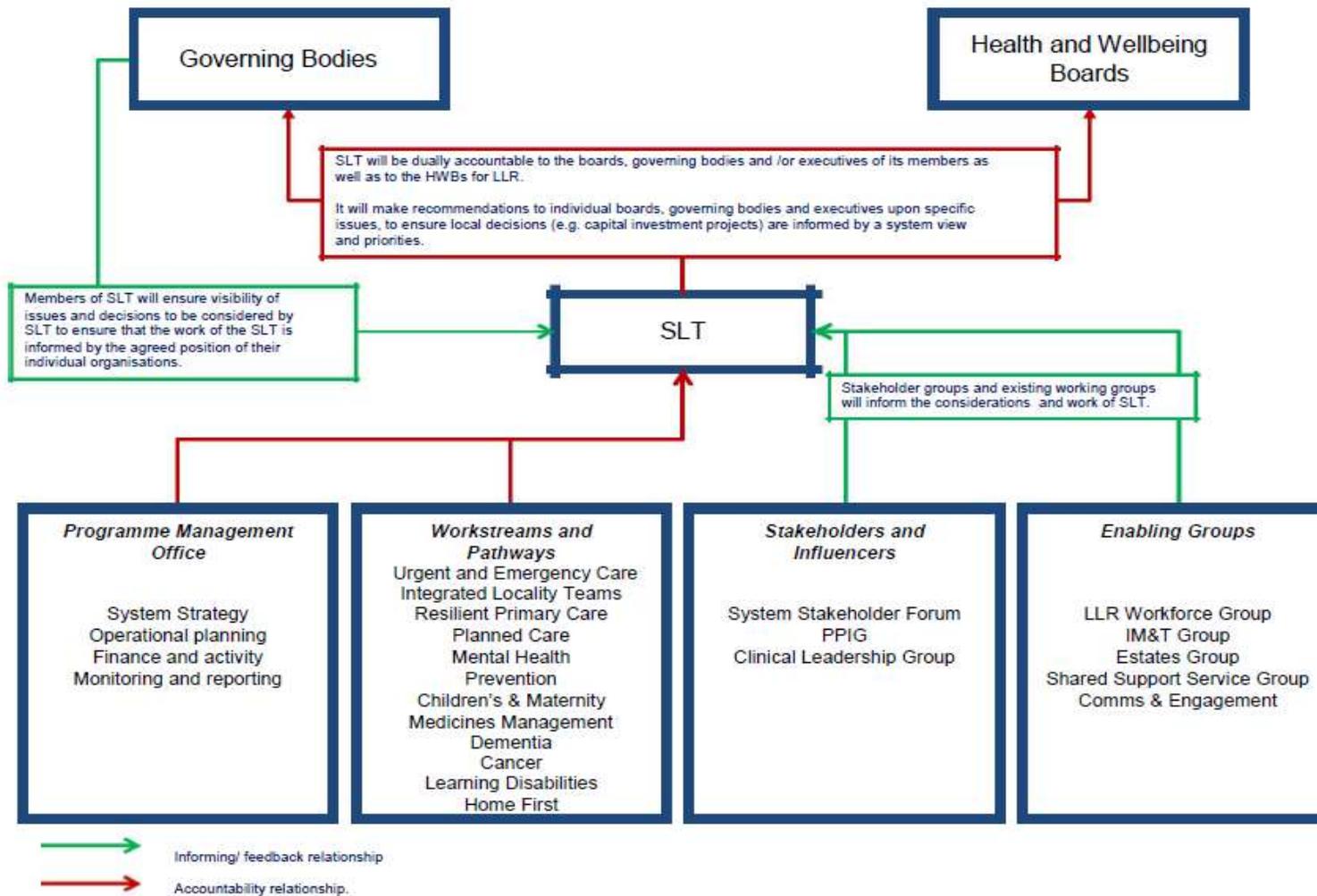
Let's work together



Better Births requires the LMS to be established on the same footprint of the local Sustainability and Transformation Partnership (STP). The commissioning of maternity services is already undertaken across an active multi-agency partnership that includes three Clinical Commissioning Groups for which plans are coterminous with the local STP. The governance for this system is embedded into the local STP governance structure across LLR and has an identified SRO at Director Level who reports to the Senior Leadership Team (SLT). Details of this structure can be seen below. Delivery of the plan will be by a number of sub groups who will report directly into the LMS board, which will monitor progress and escalate to the SLT where appropriate. Our Local Maternity System has agreed its terms of reference; it meets monthly and is chaired by the SRO and co-chaired by the Maternity Lead Commissioner.

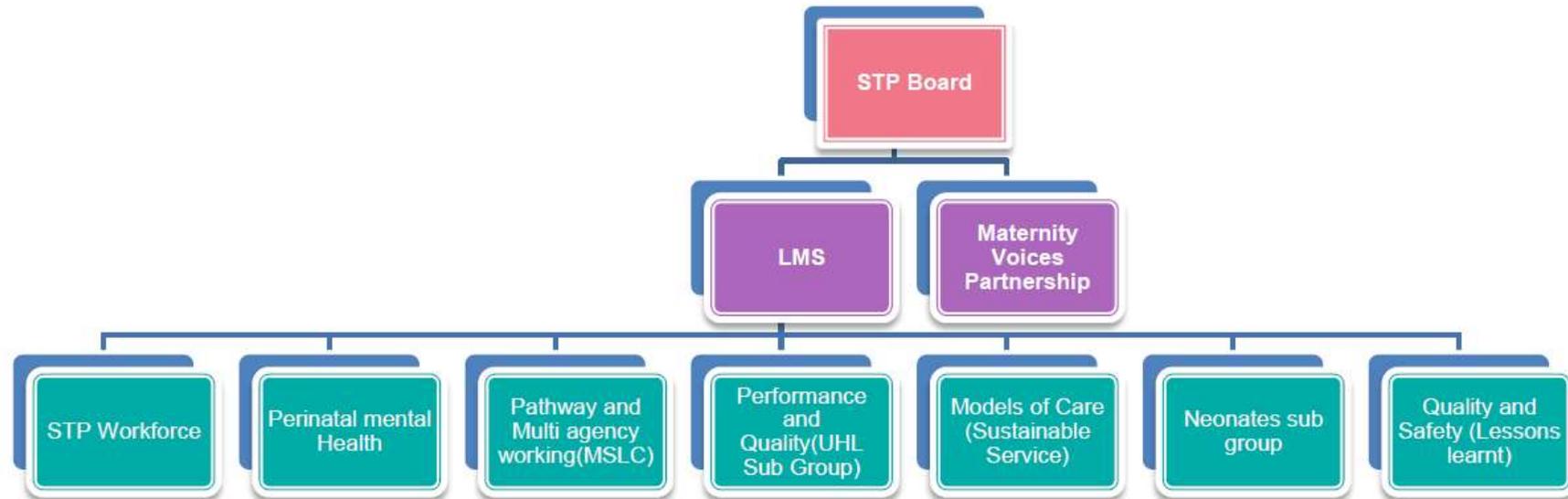
There is strong clinical leadership in the LMS and from all key partners, including patient and public representatives and Healthwatch, commissioners, maternity and neonatal providers, public health, local authorities, NHSE, maternity network and perinatal services, who all come together to work collaboratively on the delivery of our Local Maternity System Transformational Plan. This board links directly into the overarching STP governance structures which can be seen below.

4.1. STP Governance Structure Diagram



4.2. Governance Structure – LMS Governance and Delivery Structure

Governance Structure



Interdependencies:

Workforce

Estates

IT

Mental Health

Children



5. The Vision

“To provide safe, high quality care for women, their babies and their families through integrated models of care which reflects individual preferences, choice and needs based on best practice to improve outcomes and experience. These services will be supported by the appropriate infrastructure across both primary and secondary care. There will also be sufficient capacity to care for babies from LLR and the wider neonatal network requiring all levels of neonatal care, whilst consolidating and further developing neonatal services.”

We will work with local families and communities to create an efficient and affordable model of care that meets the needs of our families and offers an innovative and effective workforce model.

Our aim is to also increase the number of people who have a positive experience of our women’s and neonatal services, offering choice to women and ensuring that primary and secondary services are properly integrated and easy to access for families when they are needed. The transformational plan aims to improve health and social care in LLR between now and 2021. We are continually speaking to women and their families to discuss their experience when accessing our services and finding out what their priorities are and what they would like us to do differently.

5.1. The Model



Our model has been a co-production and is based on the outcomes of extensive and detailed local reviews led by doctors, midwives, nurses, commissioners and patient representatives. The key finding from the user engagement work was that women wanted a safe, accessible service which supported choice and continuity. A summary of the outcomes can be found in the attachments.

Stakeholder events have also been held to help develop the plan. Feedback and agreement for the model has been sought from a range of key stakeholder forums, including the Maternity Services Liaison Committee, the STP PPI forum, all three CCGs as well as being scrutinised by the STP Clinical Senate and the Regional Senate.

Our model includes how we will work through integrated pathways with collaboration from primary care, local authority and tertiary services to provide safe, joined up and personalised care. The promotion of prevention and health, as mentioned already, is a strong focus across the LMS and a key element of the model. Although Leicester City, Leicestershire and Rutland Public Health teams take the lead on prevention, the prevention work is delivered using a multi-agency, partnership

working approach. The aim of the strategy is to embed a culture whereby the prevention work stream is seen as ‘everyone’s business’ and ensuring every contact counts and as well addressing the key issues such as infant mortality and infant feeding, providing consistent lifestyle advice and support is imbedded into everything we do and captured in the personal plan.

We have developed a flexible model of care based on what women have told us and on the needs of our local population. This model will provide focused support to vulnerable and at-risk groups and focuses on empowering the mother and her partner to make choices based on up-to-date information about local and regional services. This will deliver services via a hub and spoke model, with teams of midwives working as part of a bigger multi-professional team. Access to services will be via three key routes; GP, midwife and self-referral via maternity website. The community midwife will have a key role in the pathway being the woman’s named midwife and acting as her care coordinator working closely with her GP, obstetrician (if required) and health visitor. The majority of care antenatal and postnatally will be delivered by small teams of midwives (7-10 per team) and delivered from a range of community venues including GP practices, childrens centres, community hospitals, others. Each community team will deliver a core offer of provision but, depending on needs, may also offer a range of additional services. These will be jointly delivered by midwives, health visitors and voluntary organisations. An example of this is our ‘Bumps to Babies’ parenting support package. In the city we have looked at our mixed demographic and often deliver services from culturally accepted community centres and regularly present information at cultural radio stations. Postnatally, women will receive individual care based on NICE guidance by the same team of midwives. Women will be offered choice in how to access support including drop in breastfeeding support groups.

Further details regarding models of care can be viewed within the attached Action Plan.

At booking, the woman and her partner are able to choose from a range of different pathway options depending on level of needs, including:

- Home birth
- Standalone midwife birth centre*
- Stand aside midwife lead
- Exploring developing a case holding pathway for women with high level of needs
- Level 1 and 2 delivery suites for women with complication or requesting more medical input, e.g. epidurals
- Cross boundary care from a range of providers including Nottingham, Peterborough, Kettering, Nuneaton

*The current standalone midwife-led unit is based at St Marys Hospital in Melton Mowbray which is not accessible for the majority of women in LLR and is underutilised, with 160 deliveries during the year (one birth every 2.5 days). We believe this underutilisation makes

the service no longer viable. This reflects the choice of birth option made by women in LLR as a whole, probably related to concerns about proximity to acute support for some mothers

This underutilisation of St Mary's is despite significant effort to promote the facility and as a result it is proposed to close this centre.

However, it is recognised that many women may prefer to choose to have their baby in a community-based, standalone midwifery birth centre and there should be consultation on offering this as an option on a site which provides the best equity of access for the women of LLR. Therefore we intend to consult on an option to provide a standalone midwifery-led unit at the LGH with a view to maintaining this for the long-term if there is sufficient utilisation to ensure its sustainability. As a result, these proposals would not reduce choice for the majority of women in LLR, but increase it by offering many more expectant mothers an option that was previously not practical.

The proposed model focuses on delivering the majority of antenatal and postnatal care as close to home as possible, supported by digital technology where we can and providing choice on how and where this is delivered. However, recognising the priorities of sustainability, quality and safety, it is proposed that the Hub will be a new women's hospital which will offer a range of services including screening, antenatal care for women with complications including fetal maternal medicine and a range of birth options in different environments including midwife led birth centre for low risk women and level one and two delivery suites for women with complications. There will also be a separate pathway for women having elective caesarean section or induction of labour. There will be access to HDU/ITU facilities and expertise in neonatal care.

These will all be delivered from one site; the LRI situated next to the neonatal and adult intensive care units, both vital adjacencies in case of emergencies, as well being co-located with many other important clinical services. Some maternity outpatient and day case procedures will continue to be delivered from the community hospitals with an increase in services in some cases. This proposal is based on stakeholder engagement sessions which involved detailed evaluation and a one-off event with midwives, patient representatives and interested stakeholder groups to discuss national guidance, constraints to the current service, how the service currently works, and what they might look like in the future.

We acknowledge that this proposal will create the largest single site Maternity Unit in the United Kingdom. As such it will need very careful planning to ensure a number of potential concerns are addressed. These include:

- Ensuring access to the maternity service for both outpatient and inpatient care. This will include adequate car parking and public transport access
- Ensuring there is recognition in the Models of Care of the importance of woman-centred care, offering personalised care plans and avoiding depersonalised, process-driven care

- Encouraging community based care throughout pregnancy. This will include 'normal' antenatal care in the community, use of digital technology and a Day Care Unit at the LRI to enable day attendance for monitoring and assessment of complicated pregnancies and the avoidance of unnecessary inpatient care. This will also provide home birth and birth centre options for delivery and post-natal care.
- Ensuring women have a range of choice options within the Hub. There will be an emphasis on low-risk care being provided in a home-from-home co-located Midwifery Birth Centre, which itself is expected to be divided to have different environments and staff groups for women to exercise choice. The Obstetric delivery provision will need detailed consideration and it is expected that two delivery suites will be appropriate. This will also allow patient choice where such care is required or preferred.
- Ensuring that staffing models enable the effective, supportive and appropriate care of both complicated and uncomplicated pregnancies, avoiding unnecessary interventions, in a non-medical model of care. This will also require careful review and planning to ensure the service model allows for staff to identify with the working environment and is another reason that 'separating' the services provided on the single site is most likely to be appropriate.

The delivery of the new women's hospital is dependent on securing significant capital funding and is part of the overarching STP services configuration plans to ensure clinical and financial sustainability. In light of this, we have ensured the key principles of our model are not dependent on a single site. However, sustaining safety on two acute sites would require considerable investment, which is felt inappropriate in the current financial climate and medical workforces would be the key challenge.

6. Our LMS Offer

Our transformational plan is based around the 7 key themes within Better Births, each identifying a strategic intent along with key actions and milestones. This can be found within the attached Action Plan.

6.1. Personalised Care

- centred on the woman, her baby and her family and based around their needs and their decisions, informed by unbiased information.

The strategic intent is to ensure:

- All women will have a personalised care plan and named midwife
- The personalised plan will include support re transition to parenthood, stopping smoking diet and exercises it will also highlight specific areas for the individual
- We will endeavour in increases the number of women choosing a midwife lead option 0.5%year on year

- Women will have a choice on how they receive antenatal and postnatal care, however the initial care plan may need to be reviewed if complications arise during pregnancy or in the new-born period
- Women and families will be able to make informed choice on the place of birth, taking into account their individual needs and the expected needs of their baby
- We will work towards having electronic maternity records
- Women will have information in order to make an informed choice about antenatal and new-born screening
- Women will be able to choose from a range of birth options including home birth, midwife led or consultant led within local hospital or neighbouring hospital depending on their individual needs
- Women have the appropriate support to help them adjust to parenthood

Every woman will have an individualised care plan which will be developed in discussion with them and their partner by their named midwife. This plan will include information which is focused on the woman's personal needs and will include advice around diet, drinking, smoking and exercise. It will also identify specific concerns and wishes the women may have. The key is it will be individual to her, and although it may cover similar areas for all women the plan will be specific to her needs. We are working towards having electronic personal care records to facilitate the ability to share information with other professionals and for the woman and her partner to be able to add information to make it truly individual and personalised. Our current baseline is that 50% of women have an individualised care plan. We will increase this incrementally to 100% by 2021.

The plan will also identify who the woman's key supporter (e.g. the father) will be and what role they will play. This individual will play a key role in ensuring a positive outcome for mother and baby and the plan is the opportunity to ensure that this individual is acknowledged and their needs also met. Who this person is will also vary depending on individual circumstances. The plan will be updated and reviewed throughout pregnancy and after birth and shared with health visitors. Midwives will work with other health care colleagues including GPs and Obstetricians to ensure women has good quality, evidence-based information to make informed decisions. This information will be available in a range of formats including Apps and different languages.

Women will be able to choose one or multiple providers for birth, antenatal and postnatal care, even if this means going cross-border for different elements of their care. Currently women discuss option choices with their named midwife and partner via the personalised care plan, which is updated and reviewed throughout pregnancy and after birth. Taking into account individual needs, women will be able to choose from home birth, midwife led (stand-alone), midwife led (alongside) or obstetric led. This will facilitate the offering of personal health budgets when these are implemented in the future.

The table below approximately summarises the current split in place of birth. Our aim is to increase the percentage of women choosing midwife lead options by 0.5% through promotion and development of services, including the homebirth team, year on year until the new women's hospital is built and then 1% with the overarching aim of achieving a minimum of 30% of births being midwife lead.

Current Split of Activity

Type of Birth	Percentage
Home birth	1.50%
Standalone midwife led	1.50%
Stand aside midwife led	22%
Consultant care	75%
Total	100%

6.1.1. Prevention and Pre-Conceptual Care

Prevention has been included as a fundamental element of our LMS transformation plan. Although Leicester City, Leicestershire and Rutland Public Health teams take the lead on prevention, the prevention work is delivered using a multi-agency partnership approach. The aim is to embed a culture whereby the prevention workstream is seen as 'everyone's business' and in ensuring every contact counts.

Women requiring pre-conceptual advice can be referred to a specialist clinic to receive advice from an obstetrician and a midwife. They may also receive genetic counselling if required. Most women are referred via their GP but they can also be referred from other specialist areas, such as gynaecology. Consultants from medical specialities and pathways and polices for referral are well established. We are also working with Public Health colleagues in providing timely information to young women around the benefits of a healthy lifestyle and the impact of obesity, drugs and alcohol on pregnancy outcomes.

Women who have had a previous pregnancy complication will be advised about what action to take to support future pregnancies and an individualised plan of care provided. This may include genetic counselling, referral to other specialists or just a review at the preconception clinic.

For women who are identified as being part of one or more of the following vulnerable groups, we have a specialist team of midwives who provide care:

- Teenage mums
- Homeless / Asylum seeking
- HIV / Drug / Alcohol dependence
- Previous infant mortality

- Existing medical condition
- Recognised mental health disorder
- Diabetes

Women are screened as part of the booking procedure to check their histories in relation to any of the above vulnerabilities. Details of identified women are passed to the relevant team to ensure that they are contacted and offered any additional support or services that may be required. These women will have individualised antenatal and postnatal care provided by specialist midwives. We are currently looking at expanding this element of continuity to intrapartum care as well. As part of the screening process, all women are also offered general information regarding issues such as diet, exercise, alcohol and smoking.

A Public Health midwifery consultant currently leads on overseeing all of our prevention work working closely with Public Health colleagues focusing on reducing inequalities in care provision across identified vulnerable groups.

In LLR, the number of women who qualify for access to our specialist midwife teams is much higher in Leicester City than in the county or Rutland, for example:

Indicators Related to Vulnerable Groups from Public Health LMS "Fingertips" Profiles			
Indicator	Leicester	Leicestershire	Rutland
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	53.1	11.9	8.2
Deprivation Score (IMD 2015)	33.1	12.5	9.6
Under 18 Conceptions (per 1,000 females aged 15-17)	26.2	16.3	5.7
Infant Mortality (per 1,000)	5.1	3.9	4.9

The plans for a single site women’s maternity and neonatal service have taken into account the high levels of vulnerability in Leicester City and the location will support access for this group also the team will be bases in local communities freely move out into both the county and Rutland as required . We are also plan to do further analysis in relation to our vulnerable population to agree a definition and understand numbers.

6.2. Continuity of Care

- all women will have a named midwife to reduce the number of health care professionals she sees to improve communications and outcomes. We will focus on improving continuity to vulnerable at-risk groups.

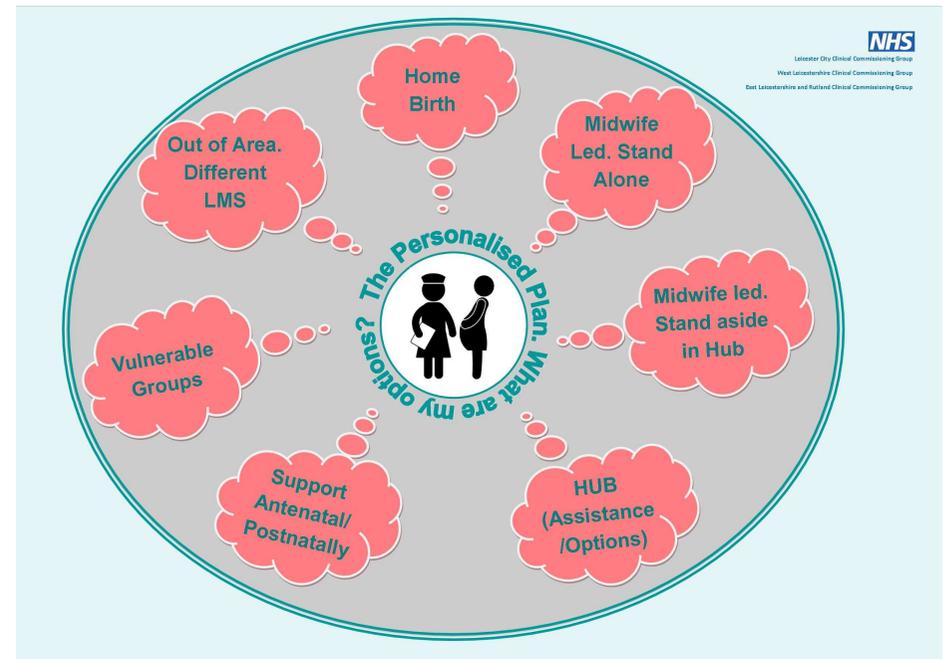
We plan to address continuity of care in two ways. Firstly, by ensuring we have *Continuity of Approach* embedded in our cultures and working practices and then working towards *Continuity of Carer*, which will focus on reducing the amount of different professionals seen by the woman throughout the entire maternity pathway. As revealed in the National Maternity Survey and confirmed by Early Adopters of Better Births, women have expressed that both of these elements are vital for good relationships to develop with their care providers.

The strategic intent is to ensure:

- All women will have a named midwife for antenatal and postnatal care
- Promotion of a culture and philosophy of woman-centred care
- Communications and key advice to women will be consistent across our teams
- Implement 'Improve It' systems to support continuity of approach across all health professionals
- Care within hospital will normally be delivered on a 2 shift system to increase the continuity of care in labour
- Midwives will work in small teams of 7-10 midwives to increase continuity
- We will explore options of developing a case holding system for vulnerable and at-risk patients
- Women whose choice is home birth will be cared for by a small home birth team
- Women will have choice on how they receive antenatal and postnatal care which may impact on continuity

6.2.1. Continuity of Approach

Through feedback from Early Adopters of Better Births, it has become clear that women feel that the information and advice they receive during pregnancy should be more consistent and less conflicting.



Alongside our plans to work towards continuity of carer, we are also focusing on imbedding continuity of approach to promote a culture and philosophy of woman-centred care and to ensure staff are all working with the same vision of improving the consistency of information. This will be supported by improved IT systems and the reduction of the number of professionals the woman sees through revised models of care. We will have engagement/training events that take place whilst rolling out our Better Births strategy across the workforce to reinforce this vision.

6.2.2. Continuity of Carer

We recognise the importance and benefits of providing the woman and her family with continuity throughout the pregnancy, birth and postnatally. However, operationally this is extremely challenging for a large maternity service and achieving the Better Birth standard will be a stretch target. As part of our pathway development and workforce modelling we are looking at further developing models of care to improve continuity. We are awaiting the outcome of the national work on this and feedback from the pilots but in the interim we are exploring both case holding and team midwifery models. To support implementation we have undertaken workforce gaps analysis using Birthrate Plus, which indicates additional capacity will be required and we are looking at how we can commission for this based on outcomes, not on tariff. The whole system transformation will take time to implement and will require support from the national work on commissioning, we are therefore planning to implement continuity over three phases:

Phase One

Our goal is to ensure all women have a named midwife and continuity in both antenatal and postnatal period. We will ensure that midwives work in small teams of 7-10 to improve continuity in the community and services within the hospital setting will be delivered across two shifts to try and improve continuity in labour. For those women who choose home birth, we are developing a home birth team who will be introduced from 36 weeks onwards. This will facilitate the likelihood that the midwife managing the delivery will have had involvement in the woman's ante-natal care and postnatal care. This service was launched in September and is now fully operational.

Phase Two

We plan to explore offering continuity across all elements for the most vulnerable and at risk groups, such as teenage mothers. To achieve this we first need to agree what we mean by vulnerable, understand capacity and workforce implications. We will also seek to learn from the national pilots and explore how this can be commissioned. Due to the amount of work that needs to happen, it is anticipated that it will take until October 2020 to identify what is required to deliver this. A business cases will then be developed for consideration by the SLT.

Phase Three

We will work towards having continuity across the whole pathway for all low-risk women. This will be delivered via teams of midwives working across community and the women's hospital. To achieve this we first need to understand the numbers of deliveries so we can develop our model and look at capacity and workforce implications and explore how this can be commissioned. Due to the amount of work

that needs to happen we are yet to confirm a go live date but anticipate the initial work will be completed by April 2020. A business cases will then we developed for consideration by the SLT.

The chart below demonstrates our current levels of continuity and out trajectories for improvement. We do acknowledge that whole pathway will be a stretch target for our LMS.

Proportion of Women who Experience Continuity of Carer across the Maternity Pathway				
Stage of Pathway	Baseline %	2018/19	2019/20	2020/21
% of women receiving antenatal/postnatal continuity by Teams of Midwives	50%	60%	80%	95%
% of vulnerable and At-Risk Groups receiving antenatal continuity by specialist midwives	70%	80%	90%	95%
% of women having home birth receiving whole pathway continuity by teams of Midwives	60%	70%	90%	90%
% of women receiving whole pathway continuity across LLR	1.5%	10%	20%	20%

6.3. Safer Care

- with professionals working together across boundaries to ensure rapid referral and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.

The strategic intent is to ensure:

We will work towards delivering the National ambition by delivering “Saving Babies Lives” care bundle to reduce Stillbirths, Neonatal Deaths and brain injury by 20% in 2020 and 50% in 2030. Current baseline is 73 neonatal deaths and we plan to reduce this by 2 in the first year followed by 3 each subsequent year.

- We will commission safe and sustainable maternity and neonatal services supported by the appropriate infrastructure across both primary and secondary care
- Multi-agency protocols and policies will be in place to ensure rapid referral between professionals and across organisations to ensure that the woman and her baby can access more specialist care when they need it
- We will have a robust approach to reviewing clinical outcomes through LMS via the local Maternity dashboards and implementation of the new national and local maternity datasets
- Improved risk assessment and surveillance for fetal growth restriction
- Improve effective fetal monitoring during labour,
- We will undertake regular benchmarking to review performance and quality, e.g. MBRRACE, Mortality and RCOG
- Existing benchmarking of neonatal services performed by the neonatal ODN will feed into the LMS governance process
- We will instigate a lessons learned panel so we can review serious incidents and ensure multi-agency learning
- We will work together in partnership to look at reducing stillbirths and improving infant mortality with the development of a joint strategy
- We will look at developing electronic maternity records to support sharing of data and information between professionals, organisations and with the woman
- We will endeavour to have the appropriate capacity and skill-mix to deliver the plan
- Reduction of Hypoxic Ischemic Encephalopathy (HIE) babies by implementing actions from 'Saving Babies Lives'. Current baseline 21 with plan to reduce by 1 year-on-year.

Our aim is to provide high quality, safe and sustainable maternity and neonatal services based on best practices which are easily accessible. These services will be supported by the appropriate infrastructure across both primary and secondary care. To support choice we plan to ensure that low-risk women will have a range of birth options including home birth and midwife-led care, including looking at the option of having standalone midwife-led services in an appropriate location which will ensure accessibility and future-proofed facilities.

There will also be sufficient capacity to care for all babies requiring neonatal care by consolidating and further developing neonatal services in collaboration with our New-born Network partners in the East Midlands. The proposal is the consolidation of all women's acute services and neonatal services onto a single site supported by a flexible, multi-disciplinary workforce that responds to changes in volume and complexity. This will require the formulation of a strategy to improve neonatal capacity (workforce and cots) including appropriate new transitional care capacity within the single site plan, and development of outreach services utilising the national CQUIN to facilitate timely discharge, improve flows and throughput in the neonatal unit. In order to avoid unnecessary term admissions and reduce maternal baby separation, development of transitional care services and implementation of ATAIN work is required.

Part of the development of the LMS will include coming together as a system to commission, monitor and review the quality and performance of maternity services. One of the key strengths within the LMS which will support us in continuing to improve quality and safety of care is our strong clinical engagement and leadership. This is coupled with close relationships with commissioners. Together we will ensure our local maternity dashboard follows the same principle as the national dashboard and work towards commissioning services based on a locally developed outcomes framework and explore the possible development of PROMs/PREMs. We will also develop a cross organisational 'lessons learned' panel to support the learning from local incidents.

To support the above we will work towards having an electronic maternity record to support sharing of data and information between professionals, organisations and with the woman. We will also continue to have annual multi-disciplinary training for midwives, obstetric staff (of all grades) and neonatologists and actively participate in multi-professional peer reviews of services to support and spread best practice.

The LMS is part of the Maternity and Neonatal Safety Collaborative and has obtained funding for the following:

- CTG training and assessment
- Sonographer training for two midwives to fully implement GROW to support Saving Babies' Lives
- Improving training and awareness of perinatal mental health for the whole team
- Improving multi-disciplinary working across the mental health pathway, including bespoke training day for up to 50 staff to review real-life cases with safety issues
- Cultivating a more compassionate culture by developing a team that works together
- 'Human Factors' and 'Train the Trainer' courses to incorporate human factors as a golden thread throughout the multi-disciplinary team.

The infant mortality rate for Leicester (2011-13) was 6.4 per 1,000 live births, which is significantly higher than the national average at 4 per 1,000 live births and the East Midlands average at 4.2 per 1,000 live births (in the first year of life). "The 2015 MBRRACE Perinatal Mortality Surveillance report highlights that our lead provider Trusts stillbirth rate remains slightly lower than the average however the neonatal death rate for 2015 was more than 10% above the average for our peer Trusts. Careful analysis of the data suggests that has arisen due to an unexpected excess of deaths of babies with congenital anomaly, especially in the 32-36 week gestation age range. The higher rate of neonatal deaths for 2015 represents an excess of 3 neonatal deaths compared to the average for our peer group. Further work is underway with public health to look at issues regarding consanguinity and reluctance with regard take up of screening and termination of pregnancy. We have set ourselves a target to maintain or improve stillbirths and reduce neonatal and perinatal deaths by 2 in the first year and then 3 per year over next four years.

A strategy and action plan has also been developed by a range of partner organisations who have come together to form the Infant Mortality Strategy Group (IMSG), in recognition of the importance of this issue an action plan has been developed and aims to deliver a multi-focus approach looking at the maternal factors, the infant factors and the wider detriments of health which are recognised to be a significant issue for Leicester. Some of these key actions included the development of a new GROW protocol to identify the potential for women to have a small for gestational age babies by assessing risk factors and use of personalised growth charts, raising awareness with pregnant women of the importance of seeking advice on reduced foetal movements, and a social marketing campaign, concerning the importance of early booking. We are promoting the national Safer Sleep campaign for babies with additional training for all midwives and updates providing targeted work and parenting support for vulnerable and at risk mums such as the 'Bumps to Babies' programme. There is also a core group looking at reducing the term admissions to neonatal services, in line with the national patient safety alert, the group is reviewing cases monthly and develop actions to help avoid admission and reducing the risk of mother and baby spending time apart following birth.

6.4. Better Postnatal and Perinatal Mental Health Care

- which can have a significant impact on the life chances and wellbeing of the woman, baby and family.

The strategic intent is to ensure:

- All women will receive postnatal care in line with NICE guidance and we will endeavour to provide choice in how and where this is delivered
- We will support the woman and her partner with the emotional elements of child birth including prematurity, separation disability and bereavement
- We will have an integrated perinatal pathways which identifies women early and provides assessment support and treatments close to home to minimise need for admission to mother and baby units
- We will work together to reduce the number of term admissions to and ATAIN
- We will endeavour to ensure babies requiring specialist neonatal care surgical or cardiac are cared for in the right cot as close to home as possible

All women will receive personalised postnatal care in line with NICE guidance and we will endeavour to provide choice in how and where this is delivered, although we acknowledge that choice could impact on continuity. We will support the woman and her partner to adjust to parenthood and provide specialist support and input if required including support for couples who have experiences a dramatic or unexpected pregnancy outcome, including the loss of a baby, and we will work with partners to avoid separating mothers and babies. We

also intend to look at offering women the choice of having their partners stay overnight, however this will need to be phased in due to the current restrictions in relations to estates.

For couples who have experienced a pregnancy loss we will offer care from a specialist midwife who will offer support, arrange appointment debriefs and may case hold in future pregnancies. We are also utilising the national bereavement tool.

Some babies may require additional support but not need neonatal facilities. To address this we have developed transitional models of care. This is an integral part of the maternity single site development. However, some babies will need admission to the neonatal unit. It is vital they get the specialist treatment timely and ideally that baby is born in a unit that has the right intensive care facilities. As the lead centre for the NNU network we will work to support colleagues to ensure babies are transferred in utero <27 weeks to ensure they get the right NNU support. The key elements required to deliver this are, sufficient NNU capacity and appropriate obstetric transfer capability. We will work with NHSE commissioner colleagues to support this and the proposed single site model for LLR will help to ensure this is achieved.

Admission of babies to the neonatal unit leads to psychological distress for parents we will work to reduce the number of babies that go to the unit and support the national ATAIN by review all term babies, looking at themes and developing an action plan to prevent avoidable admissions. Many parents require additional psychological support during this time. Psychological services are an integral part of neonatal care and availability and access is essential and we are looking at how we can develop additional resources in this area.

Some women will require joined up support with perinatal mental health services. Perinatal mental health disorders are those that complicate pregnancy and the postpartum year. They include both conditions with their onset at this time and pre-existing conditions that may relapse or recur in pregnancy or the postpartum year. Psychiatric disorder is a leading cause of maternal death. It has caused 12-15% of all maternal deaths in pregnancy and six months postpartum since 1997.

There has already been significant local investment in the community perinatal services to improve outcomes for this vulnerable group. The local LLR's Perinatal Mental Health Service provides assessment, intensive support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services. They also assist in the detection and proactive management of women who are at risk of developing a serious perinatal or postnatal mental illness and provide advice and assistance to primary care, maternity and psychiatric services on the treatment and management of serious perinatal mental illness. We also have a specialist mental health midwife in place that links with the team and undertakes joint clinics, and we have access to regional and national training days. The core principle of LLR's Perinatal Mental Health Service is to safely and effectively meet the special needs and requirements of mothers and infants in a community setting. We are currently reviewing the pathway to ensure optimum outcomes and efficiency and developing a bid to further expand this provision to ensure it meets national standards. A bid is being developed in partnership and in conjunction with the East Midland Perinatal network to increase capacity to meet more women's needs in line with

national ambition. Also, as part of the safety collaborative, we have obtained funding to improve training and awareness of perinatal mental health for the whole team. Over a twelve month period, the LMS will use the online training for perinatal mental health and deliver this to all staff, combining mandatory training days with a perinatal mental health multi-disciplinary working day to engage teams and examine how they can work together in a safer and more meaningful way.

6.5. Multi-Professional Working

- breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

The strategic intent is to ensure:

- We will deliver a hub and spoke model services delivery by midwives within multi-professional teams, with some cases holding teams for specific groups. Care will be delivered from a range of different venues including children's centres, GP practices and community hospitals
- We will continue to develop integrated pathways across primary, secondary and tertiary services to ensure appropriate support for women and families including at risk groups, e.g. Downs's pathway, teen mums, MH and prematurity
- We will establish a LMS and come together across our STP footprint to commission safe and sustainable maternity services and endeavour to support joint training across key professional groups
- We will be active members of the local and national clinical networks to share data and actively contribute peer review and benchmarking activities
- We will work with Public Health to endeavour to improve women's and babies life changes by making every contact count and provide health and life-style advice and support including stop smoking , exercise and diet

Our model includes how we will work through integrated pathways with collaboration from primary care, local authority and tertiary services to provide safe, joined up and personalised care. Prevention and health promotions, as already mentioned, are strong focuses across the LMS and a key element of the model. The community midwife will have a key role in the pathway, being the woman's named midwife and acting as her care coordinator whilst working closely with her GP, obstetrician and health visitor. She may also work with colleagues from other LMS if a woman has chosen to deliver elements of her care across boundaries. This integrated pathway will be supported by the LMS and the local commissioning arrangements that will be put in place.

Transition to parenthood can be a difficult time for many women and their families and unfortunately families with the greatest needs are often the least likely to receive the support they require. The first year of a baby's life is known to be the most important and can have a long-term effect on the child's development. Parents need to receive appropriate support from a multi-agency, multi-professional team.

Midwives and obstetricians play an essential role within this team alongside public health specialists, GPs, health visitors, social workers, parenting support workers and the voluntary sector via organisations such as breastfeeding peer supporters.

We will continue to develop integrated pathways and look at delivering services through a hub and spoke model with the community midwife being the woman's care coordinator; ensuring she is able to access a range of professional advice and support in both community facilities such as children centres, community hospitals, and GP practices and specialist services if required. The multi-disciplinary team will provide information on the importance of a healthy lifestyle, signposting where necessary to address key health issues such as exercise, diet, smoking, drugs, alcohol, immunisations and screening.

6.6. Working across Boundaries

- to provide and commission maternity services to support personalisation, safety and choice; with access to specialist care whenever needed.

The strategic intent is to ensure:

- We will establish a LMS and come together across our STP footprint to commission safe and sustainable maternity services
- We will establish a commissioning framework that supports choice and the development of personal health budgets (PHB) which will be outcomes focused
- We will be active members of the local and national clinical networks to share data and actively contribute to peer review and benchmarking activities
- We will develop systems and processes to support activity across the networks

Locally we have established a Local Maternity System, built on the same footprint as the local Sustainability and Transformation Plan (STP), to commission maternity services. This is an active multi-agency partnership which includes three Clinical Commissioning Groups. The governance for this system is imbedded into the local STP governance structures across LLR and has an identified SRO at Director Level who reports to the STP Board. Details of this structure can be seen in section 4 on governance (p. 18).

This partnership has already seen the implementation of a local maternity dashboard to aid the development of partnership pathways and strategies to support transition to parenthood, infant feeding and reduced infant mortality. It also has an existing maternity services liaison committee which will support in the development of local maternity voices partnerships. This provides us with a good foundation on which we can continue to build on when looking at continuing our transformation in line with Better Births.

6.7. Reformed Payment System

- that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

The strategic intent is to ensure: -

- We will establish a commissioning framework which supports choice and the role of PHB
- We will work with cross boundary providers and commissioners to facilitate choice and ensure quality
- We will work towards commissioning services bases on outcomes

We currently commission services in line with the national maternity tariff. Last year the LMS budget was 57,148,341 .The large percentage of the budget was spent of services in area however there was an out of area spend of 11,269,219 across 6 other cross-border providers. It is envisaged that the majority of services within this transformation plan will be commissioned in line with the national maternity tariff however some elements do lie outside of this, including the 0-19 public health pathway, neonatal services and perinatal mental health. Commissioners will work together to ensure all elements are aligned to prevent both duplication and gaps. If a commissioning gap is identified, this will be addressed via existing commissioning processes and business cases will be developed and actioned via the STP process. A key example of this has been the development of a business case to secure capital funding for a new women's hospital as part of this plan, for which we are currently awaiting an outcome.

We will ensure that the commissioning framework continues to support women choice. Women will be able to choose one or multiple providers for birth, antenatal and postnatal care even if this means going cross-boundary for different elements of their care. We will continue to work with our cross-border providers and commissioners to ensure the continuation of this offer, improve quality and strengthen joint working to improve continuity of care. Currently, women discuss their option choices with their named midwife and partner via their personalised care plan, which is updated and reviewed throughout pregnancy and after birth. Taking into account individual needs, women will be able to choose from home birth, midwife led (stand-alone), midwife led (alongside) or obstetric led. This will facilitate the offering of Personal Health Budgets when these are implemented in the future.

We will also work towards commissioning maternity services based on outcomes. Commissioners will continue to work with providers to look at current specifications and utilise the national maternity specification to ensure we focus on outcomes; developing KPIs to support improvements in care and empowering providers to make service improvements by monitoring and reporting their own progress regularly.

7. Workforce: Staffing Levels and Skill Mix

The strategic intent is to ensure:

- We will endeavour to have an effective and efficient workforce with the appropriate skills to deliver safe, high quality maternity, obstetric and neonatal services
- Prioritise the health and wellbeing of our staff with the 'Caring for You' campaign
- Continue to develop a woman-centred culture to support implementation of Better Births
- Explore the role of the multi-disciplinary teams and the development of generic roles
- Endeavour to have the right skill-mix of midwives, obstetricians, neonatologists, nurses and allied health professionals for the services
- Review the roles and skills of staff to ensure that we can meet the needs of the population

The workforce needs to be developed to ensure we have appropriately trained and skilled staff to meet the needs of women and their babies (Chief Nursing Officers Report). The right workforce is crucial to support us in delivering our models of care and ensuring that we can meet needs and improve outcomes. The implementation of the strategy through the development of care pathways will inform the workforce plans for Leicester, Leicestershire and Rutland. We will explore the opportunity to have generic roles across organisations to support women in preparation and adaptation to parenthood such as midwifery assistance. We will also review the skills required to support vulnerable women with issues such as HIV and teenage pregnancy.

We also recognise that to deliver continuity of care that we will need additional midwifery resource and we are currently looking at the workforce impact of this, the cost implication and practicality of recruiting these additional midwives on top of ensuring we maintain current capacity despite attrition due to retirement. The current number of local midwives is in line with what is commissioned however a recent review using Birthrate Plus equity tool identified that we need more midwives than the current tariff payment supports, we are developing a business case to request additional capacity to address this. This workforce analysis also demonstrated that just 9.7% of the midwifery workforce is made up of midwifery support workers and Better Births indicates that it is appropriate to have up to 22%. We are therefore exploring increasing this but we are mindful of our high acuity and the need not to dilute the workforce so that we reduce quality of care. We also currently have separate theatre teams and nurses who help support the service.

Our key workforce challenges relate to some significant medical staffing issues for both maternity and neonates at middle grade and junior doctor level which is exacerbated by being split across more than one site. Increasing the presence of consultant obstetricians on delivery suites has shown to reduce caesarean section rates and complications of operative vaginal deliveries. Current recommendations state that consultant obstetricians should be present on delivery suites for a minimum of 60hrs for units delivering over >6000 deliveries. We currently struggle to meet this standard and this is one of the key safety drivers for the move to the single site unit along with the growing issue with neonatal staffing, in both medical and nursing.

Work on the new models of care will help to address this but in the short term it is providing significant challenges and lack of obstetric sonographers and neonates nursing vacancies are adding to the pressures. We have worked with HEEM and local universities to look at number of training places and ways of address shortage, we are also awaiting outcome of national workforce review which we will feed into the work.

As part of new workforce models, we are also prioritising the health and wellbeing of our staff. We are imbedding the 'Caring for You' campaign into what we do, looking at the results of staff surveys, establishing staff focus groups of Better Births 'champions' to improve communications and providing emotional health and wellbeing training for staff. We acknowledge that any change in working methods, including possible changes to case load and shift patterns, could have a detrimental impact on the wellbeing of our staff. To minimise this, we will hold workforce engagement events in multiple locations to ensure that staff are kept up-to-date with any changes that are being considered, and make sure that an open channel of communication is maintained so that staff can contact the LMS with any concerns that should arise. Through the inclusion of the workforce in the design of any proposed changes, we are hoping to reduce the potential for affecting staff wellbeing and improve overall morale by giving staff more control over their working methods.

Locally there is already a strong culture of services being woman-centred. However, it is acknowledged that some staff will have concerns about the proposed new model and if we are to be successful in implementing our local LMS plan, it needs to be believed in and understood by staff on the ground. To support this we have appointed a clinical midwife as part of the PMO and we are planning to identify Better Births 'champions' across the service. We also plan to establish a news letter and forums where key members of the pathway, e.g. midwives and health visitors, can share their views on how the plan is working on the ground and suggest changes.

Workforces review and development is being lead through the STP workforce steering group and the women's models of care are supporting this work by exploring the opportunity to work differently to provide safer and more sustainable long-term workforce solutions, particularly in areas where there are current workforce shortages.

8. Engagement

The strategic intent is to ensure:

- Robust mechanisms are put into place to 'sustain an effective forum for involving service users' in the development of maternity services, as detailed in the LMS guidance.

The LMS will create an environment where it will:

- Develop a Maternity Voices Partnership

- Truly understand what women (and their partners) want
- Be able to demonstrate that we are listening
- Engage directly with staff in multiple, easy to reach locations to communicate our plans for Better Births
- Gather feedback on the current and potential future models of care
- Make changes based on what we learn from this feedback
- Engage widely with patients, carers and the public on the transformational plan

“Patient and stakeholder feedback holds an important place within the NHS. By capturing the views and opinions of those who use health services, it offers us a unique insight into the experience of the patient and, through this, into the quality of the care they receive. More importantly, listening to service users is also the right thing to do; there is a strong moral case for focusing on the experience of patients and for seeking to improve this.” (Goodrich and Cornwell 2008)

Locally this view has been supported and over the past 10 years we have striven to strengthen the voice of the users in all that we do. Key mechanisms and processes we have used to obtain the voice of the users include engagement events, as part of the Darzi Review (2010), and local reviews of maternity services, as part of the better care together work and STP.

We continued to engage with stakeholders throughout the development of the BCT plan and now the local LMS plan. This plan has been through several stages of review and has been agreed by our STP processes. This has included stakeholder events held to help develop the plan. Feedback and agreement for the model has been sought from a range of key forums including the Maternity Services Liaison Committee, GP forums, the STP PPI forum and all three CCGs. It has also been scrutinised by the STP Clinical Senate and the Regional Senate.

The next stage of engagement will be in line with STP process and will include being presented at overview and scrutiny committees as well as a formal engagement and communication process. We are currently developing a public facing version of the plan and intend a public launch in line with STP processes.

CCGs linked up with Healthwatch to undertake a survey focused on maternity services which will support us in our planning and commissioning of services. Our models have been co-produced and are based on the outcomes of extensive and detailed local review, led by doctors, midwives, nurses, commissioners and patient representatives. The key findings from all the user engagement work we did was that the women wanted a safe, accessible service which supported choice and continuity. A summary of the outcomes can be found in the attachments.

We are currently in the process of reviewing the recent publication of the CQC Maternity Survey to see how this may influence/change aspects of the plan. We also hope it will help us determine the areas where we need to concentrate and prioritise our work.

We have developed a new engagement strategy which details how we plan to engage with women and their families on proposals to develop a maternity transformation plan as part of the LLR Local Maternity System. It describes a sustainable structure for embedding service users, carers, and public involvement throughout maternity services across Leicester, Leicestershire and Rutland. Historically, the LLR Maternity Services Liaison Group has been involved in helping staff to engage with women and their families on developing maternity services. It is hoped that this will work alongside a larger Maternity Voices Partnership (MVP) which will have a yearly action plan to ensure it is embedding patient and public involvement in a systematic way. Key to the success of this strategy is having the right capacity and support to deliver it. Therefore, we plan to utilise some of the non-recurrent funding allocated to the LMS to appoint an engagement lead and support establishment of the MVP. We also plan to have a launch event in early 2018 and develop a more user-friendly version of the plan.

To support engagement and roll out the LMS plan we will be recruiting Better Births 'champions' from the existing workforce to improve communications across different teams. These champions will work closely with the Better Births Midwife that has been recruited as part of the PMO to create a clear channel of communication between all staff, from the teams of professionals visiting local women to the LMS Board. This will also allow rapid dissemination of up-to-date information across the LMS through pre-defined individuals that act as representatives for different teams within the LMS workforce.

We have also commissioned a number of short videos to communicate the different choice options available to women across the LMS. These videos take into consideration the varied demographics in the area, and will hopefully help women understand the options that are available to them.

9. Implementation and Monitoring of the Plan

Implementation and monitoring of the plan will be via the governance structures referred to earlier. Each key area will have an identified lead who will report back to the LMS Board on progress. Progress will be monitored using both a programme dashboard and KPIs. These are currently under development. Progress will be reported directly to the STP by the SRO who will also escalate issues where appropriate.

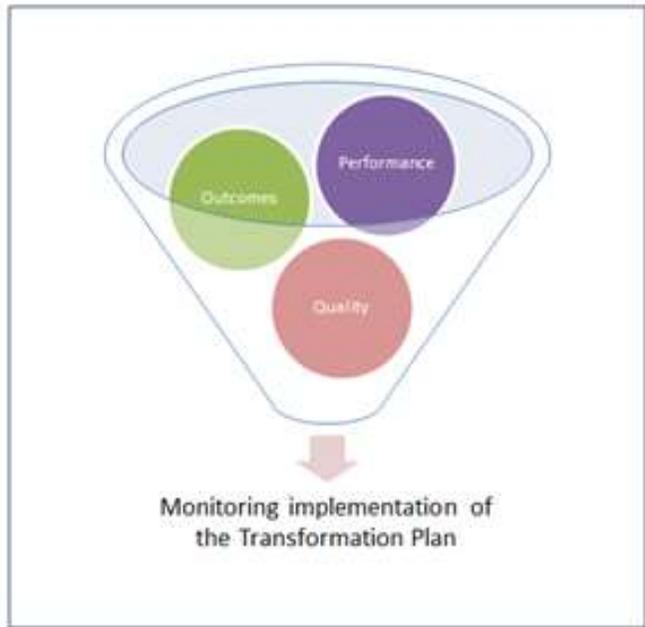
The LMS Board will utilise existing quality assurance and governance processes to ensure the actions identified in the Transformation Plan are completed with observed improvements in outcomes and experience.

High level accountability for the success of the Transformation Plan sits with the STP Leadership Board. This is delegated to the Local Maternity System Board, chaired by Leicester City CCG Director of Nursing & Quality, who is the Senior Responsible Officer for Maternity

within LLR. The Board has senior representation from all agencies involved with commissioning and providing maternity services within LLR.

Due to the volume of national, regional and local data available, the Local Maternity System Board relies upon the committees and groups within the governance structure to analyse and critically appraise the information provided, ensuring actions are taken to address areas for improvement. The governance structure is presented earlier in the plan. Triangulation of data is undertaken by the commissioners to identify any themes. Key themes from the data analysis are escalated to the Board.

Data provided broadly falls into 3 key areas; Performance, Quality and Outcomes. The chart below details the information within each:



Quality

- Serious Incidents
- Complaints
- Infection Prevention & Control
- Workforce
- Local and National Clinical Audits
- Mortality Reviews
- Saving Babies Lives Report
- Quality Visits

Outcomes

- Infant Mortality Data
- Public Health Demographic Data
- National Maternity Patient Survey
- Service User Group Feedback

Performance

- Maternity Dashboard
- MMBRACE
- Nursing Metrics
- DoH Neonatal Toolkit
- ATTAIN
- Safety Thermometer
- Peer Review Findings

Personalised Care

- We will improve the score for "The Start of Your Care in Pregnancy" section within the Biennial National Maternity Patient Experience Survey year on year using the 2015 score of 6.0 as the baseline
- We will monitor the quality of the personalised care plans through local clinical audits, taking actions required to improve care plans where findings indicate

Continuity of Carer

- By 2020 we will have fully embedded small teams of midwives with robust processes in place to enable clear communication and sharing of information ensuring women receive a co-ordinated service

Safer Care

- We will undertake a review of the incident management process, from reporting through to implementing learning
- The maternity quality dashboard will evidence continuous improvement in the safe care provided. The dashboard includes key KPIs such as blood loss, 3rd and 4th degree tears, admission to neonatal units, HIE and cooling
- We will reduce infant mortality using the national MMBRACE report as evidence

Postnatal and Perinatal Mental Health

- Perinatal pathways which includes access to mental health services will be fully operational
- Postnatal services will be compliant with NICE guidance evidenced through an audit of practice using the NICE Quality Standard 37 Postnatal Care

Multi-Professional Working

- Integrated pathways detailing multi-agency working will be fully operational
- The Local Maternity System Board will evidence engagement of the various agencies involved in maternity provision through the monitoring of attendance and active participation in workstreams and committees

Working Across Boundaries

- The Local Maternity System Board will actively participate in, and work with, the LLR STP and evidence this through STP Updates
- The commissioning framework for maternity services will clearly evidence how the CCGs have considered and commissioned services to provide personalised and safe care

Reformed Payment System

- Personalised Health Budgets will be implemented as per national guidance
- Availability of choice of care will be monitored through the Biennial National Maternity Patient Survey