Better Health, Better Care, Better Value Partnership:
Coventry & Warwickshire Local Maternity System (LMS) Partnership

Update/Progress report

1. Purpose

The purpose of this paper is to provide a brief update to the Overview and Scrutiny Committee on progress with Coventry & Warwickshire's Local Maternity System (LMS) work programme, following on from the overview of the work programme presented at the October meeting.

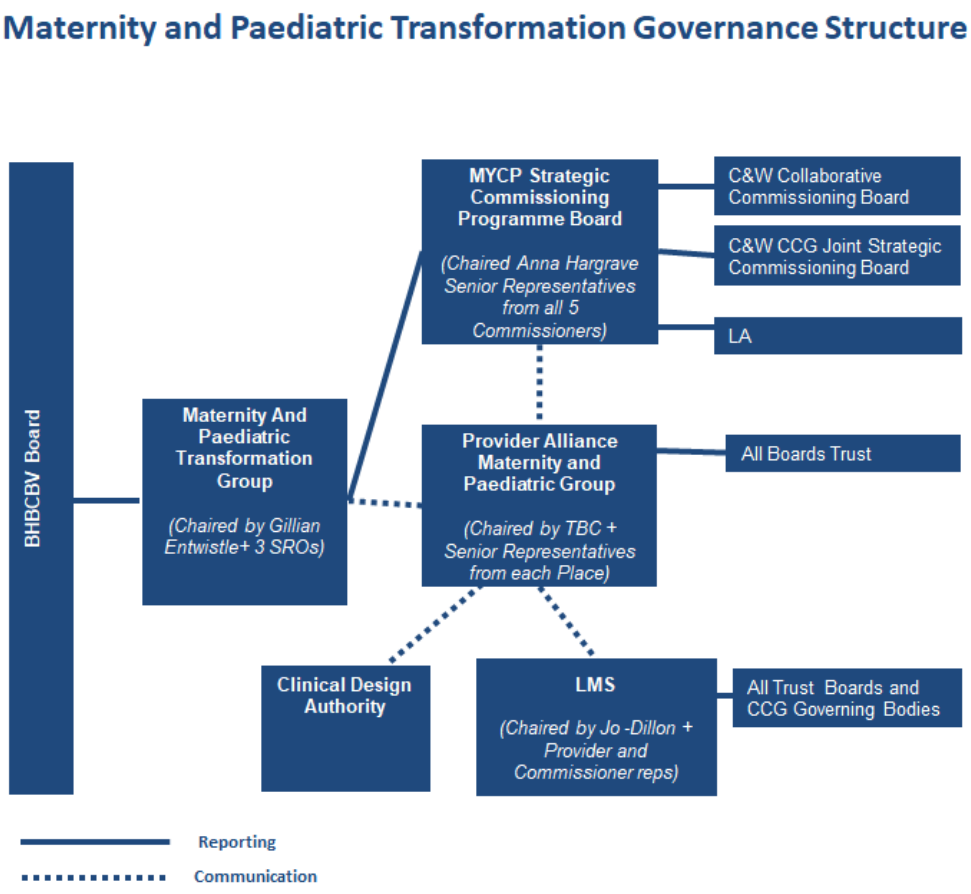
2. LMS and Wider STP

There are two significant programmes of work being undertaken by the Coventry and Warwickshire health and care system that impact upon maternity and paediatric services. These are:

- Implementation of Better Births (2016) being led by the LMS
- The Maternity, Children and Young Peoples (MCYP) Strategic Programme that has a much broader scope that extends from the antenatal period to adulthood (from 0-25); mental and physical health; prevention and early intervention, recognising the impact of the wider determinants of health.

Whilst there has been collaborative working across the two programmes there is now a recognised need to improve alignment and consequently a joint governance structure is being introduced to allow the activities of both programmes to be co-ordinated and dependencies managed. The structure is illustrated in figure 1. This alignment will help facilitate key developments within the LMS programme, in particular in relation to the 'Choice and Personalisation' plan that will be dependent on a revised clinical model for maternity and neonatal services across Coventry and Warwickshire (see section 4.3 below).

Figure 1: Coventry & Warwickshire Maternity and Paediatric Transformation Governance Structure



The LMS work programme is led by the LMS Board which has multiagency representation, including the designated leads for each of the 3 work streams and includes lay representation. Each of the work stream leads convene regular meetings and are held to account for delivery by the Board. NHSE also provide an assurance role – providing both support and challenge to the work programme.

3. LMS Vision

The LMS was established to specifically focus on transforming maternity and neonatal services to deliver improved outcomes for mothers and babies through a healthy pregnancy and safe birth in the preferred place, supported by a known midwife. This is to be achieved through delivery of:

- The recommendations of Better Births;
- The recommendations of 'Saving Babies' Lives';
- The recommendations of the West Midlands Neonatal Review for which the LMS is responsible.

Better Births sets out a vision whereby:

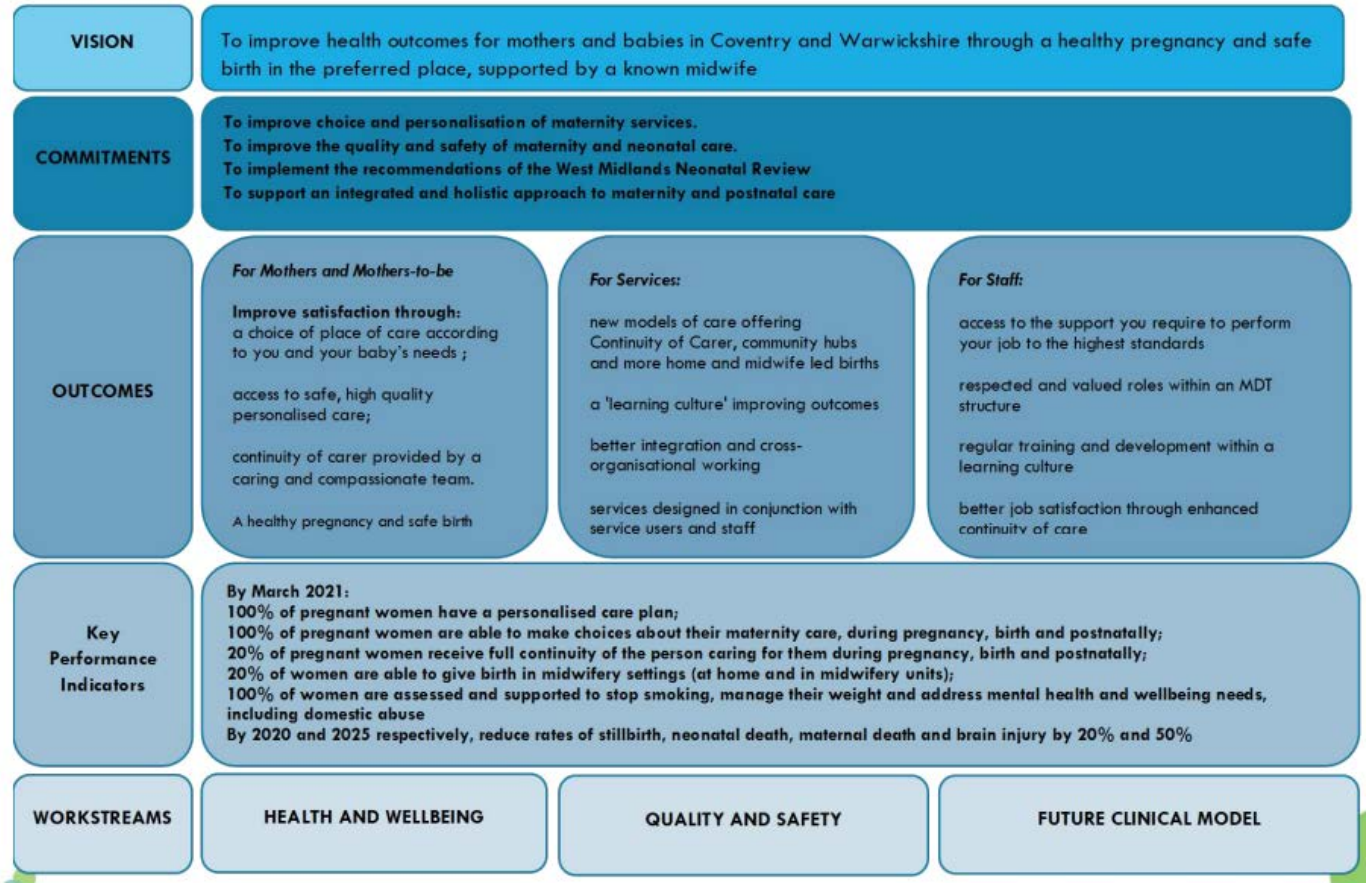
- All women have a choice of where they give birth: obstetric unit, midwife led unit or at home;
- Community midwifery services are better integrated with other family-centred health and well-being services in community hubs;
- A woman's care is personalised to her and she can have a high expectation of continuity of carer throughout pregnancy, during birth and postnatally;
- Her care and that of her baby is safe and optimises their health outcomes for the future, including access to the full range of mental health and well-being services, if required.

Delivery of the LMS vision is underpinned by a set of commitments being taken forward through three work-streams as follows:

- Quality and Safety
- Choice and personalisation
- Health and well-being

These are set out in Figure 2 on the next page.

Figure 2: Coventry & Warwickshire LMS Plan on a Page



4. Work Stream Updates

4.1 Health and Wellbeing Work-stream:

The core aim is to optimise the health and wellbeing of mothers to be, mothers and infants through effective practice and integrated working across the system.

Anticipated Outcomes:

- Reduction in Maternal and Neonatal Mortality and Morbidity
- Reduction in smoking in pregnancy
- Reduction in maternal obesity and gestational diabetes
- Increased Breastfeeding rates – at birth and at 6 weeks
- Reduction in perinatal mental health issues, such as depression in the antenatal and postnatal periods
- Reduction in Neonatal care admissions and lengths of stay.

This work stream includes seven strands of work as follows:

Parent-Infant Mental Health & Well-being (PIMHW	During pregnancy, and in the year after birth, at least 10% of women are affected by a range of perinatal mental illnesses. If left untreated, this can have a devastating impact on mothers and their families. Through early identification and expert management it is possible to prevent the onset and escalation of perinatal mental illness and much can be done to support women preventing negative impacts on the family. A specialist team, comprising perinatal psychiatrists, psychologists and community psychiatric nurses has been commissioned but further work is being taken forward through an LMS Perinatal Infant Mental Health and Wellbeing (PIMHW) Steering Group. A 5 year strategic plan has been developed and progress includes:

	• Work underway to develop and strengthen PIMHW Pathways across the LMS and to plan a mulit-agency workforce development programme. • Implementation of a training programme for evidence-based video interactive guidance (VIG) provision (seven health visitors to become accredited VIG Guiders by end 2091-20). • Business Case for a cadre of specialist mental health midwives and health visitors developed. Work underway within the LMS, Coventry & Warwickshire Mental Health Commissioning and WCC to try and identify funding. • A local 3rd sector organisation is working with Parent Infant Partnership (UK) to look at the potential of establishing a Parent Infant Partnership (PIP) across the LMS (with support from a local benefactor).

Stop Smoking in Pregnancy (SSiP)	Smoking in pregnancy is a key risk to both the health of the mother and the unborn child. Women who smoke in pregnancy are more likely to experience intra-uterine growth restriction, pre-term birth and/or stillbirth. It poses the single largest risk to a healthy pregnancy and as such all women are encouraged to quit at booking and if necessary at subsequent points along the antenatal pathway. Substantial work has been undertaken in improving pathways to SSiP services and midwives and other staff have been trained to offer women brief advice. There is however variability in smoking rates at delivery across the County and further work is required to address this. Current work includes: • A Task & Finish Group is close to finalising SSiP guidelines for implementation across the LMS. • A 2019/20 LMS funding bid has been submitted to support a strategic and operational review of smoking in pregnancy, with an audit to benchmark provision against guidelines and to help identify gaps and priorities/next steps. There is also a need for place-based Lower Super Output Area (LSOA) data capture and analysis to consider the need for targeted interventions.

Universal perinatal parenting education	There is good evidence that well designed perinatal parenting education programmes help parents understand and shape positive relationships with their infants. This in turn helps their infants to develop emotional and behavioural self-regulation skills - increasing their long-term resilience and mental wellbeing. In Warwickshire, Smart Start research (involving 1,135 Warwickshire parents) found a paucity of free or low cost perinatal parenting education opportunities and inequity in access. These findings are echoed in Coventry. In response, the LMS has prioritised the need to develop and implement place-based Universal perinatal parenting education offers. Current activities include: • Work underway at South Warwickshire to begin to pilot a delivery of universal antenatal parenting education as part of SWFT's Continuity of Care model • Development of this model will include the creation of social connections and 'peer to peer' educators who will work alongside professionals • Additional capacity/resource required by GEH and UHCW midwifery to work with public health to drive forward place-based universal antenatal parenting education offer in North, Rugby and Coventry. Bid submitted for 2019-20 LMS transformational funding. • Recognition that to succeed in offering a universal antenatal parenting education in the north of Warwickshire and Rugby there will be a need to take an asset-based approach to delivery with third sector and peer to peer provision.

Obesity in Pregnancy	Around 1 in 5 women attending antenatal care in the UK are obese. In some areas of the LMS this reaches 1 in 4. Having a higher body mass index at the start of a pregnancy, and excessive gestational weight gain, increases the health risks to both the mother and infant. A LMS 'partnership approach to physical activity and reducing obesity' workshop in November 2018 recognised that there are inconsistences in the LMS 'obesity in pregnancy' pathways, and there is a need to review and strengthen these pathways. • Before the pathways can be reviewed and benchmarked there is a need to develop up to date guidelines for the identification and management of obesity during and after pregnancy. The timeline for guidelines development not yet confirmed but is anticipated to be in the next 3 or 4 months.
Parental conflict and domestic violence	There is a large body of evidence that shows that conflict between parents can have a negative impact on children's long-term mental health and future life chances. Parental conflict can then in turn act as a precursor to poor parenting practices. In most recent estimates (2013/14), the proportion of children living in couple-parent families whose parents had 'distressed relationships' was 11.4%, and 28% of children living in workless families live with parents in a distressed relationship. This is almost three times higher than for children where both parents are working (10%). Parental conflict is a potent pre-cursor to domestic violence and as such is an issue that needs to be addressed through LMS pathways. With this in mind: • A LMS scoping meeting is to be held on 23 May to decide on next steps for this strand of work.
Infant Feeding	There is a vast body of evidence to support the importance of breastfeeding for short and longer term health of the mother and the infant. Since 2015 we have seen a downward trend in breastfeeding rates in Warwickshire. In 2018-19, the average rate of breastfeeding at 6-8 weeks was 47.9% (England 46%). This is lower than many of our statistical neighbours. Warwickshire parents report insufficient support in the early days of breastfeeding, and midwives express concerns about a lack of capacity to offer quality support. • There is an acknowledged need to improve infant feeding support for parents. This will include an LMS review of infant feeding support pathways to identify good practice and geographical variance. • Recognition that – given midwifery services capacity - to succeed in strengthening breastfeeding support and outcomes there will be a need for an asset-based approach to delivery with third sector and peer to peer provision**.**
Community Hubs	Better Births identified that maternity services should be organised around the woman and her family and that Community Hubs should be identified to enable access to services needed. It was recognised that the LMS will need to identify a range of services to be brought together through the community hub based on the needs of the local community, infrastructure available and the pathways/services commissioned. Provisional work was undertaken across Warwickshire with a view to identifying potential Community Hubs for LMS services and whilst venues have been agreed in the South of the county there was a view that the model of care (to be agreed through the Choice and Personalisation work programme) would need to be clearer before hubs in Rugby and in the North of the county can be identified. Alongside this NHSE (Maternal and Perinatal Clinical Networks) has undertaken a mapping exercise of

	hubs across the country with a view to identifying hub locations across geographical boundaries. The findings of this work will help inform the future identification of hubs elsewhere in Warwickshire.

4.2 Quality and safety:

The overall aim of this work stream is to optimise health outcomes for mothers and babies through the provision of high quality, safe services.

Anticipated Outcomes:

- Reduction in Maternal and Neonatal Mortality and Morbidity
- Reduction in Neonatal care admissions and lengths of stay
- Increase in continuity of carer

This work stream is led by the Heads of Midwifery at SWFT, GEH and UHCW and includes a number of work programmes/developments as follows:

- (i) Implementation of the Saving Babies Lives Care Bundle
- (ii) Participation in the Maternal and Neonatal Safety Collaborative
- (iii) Continuity of Carer for women antenatally, during delivery and throughout their maternity pathway
- (iv) Perinatal Mortality Reviews
- (v) Learning from incidents and complaints
- (vi) Development of shared clinical guidelines for implementation in SWFT, GEH and UHCW
- (vii) County Wide Safety Huddle

Saving Babies Lives Care Bundle (SBLCB)	Implementation of the initial Saving Babies Lives Care Bundle (SBLCB) was required by March 2019 and is specifically aimed at reducing stillbirth rates. This development included 4 separate elements as follows: • Element 1: Reducing smoking in pregnancy • Element 2: Risk assessment, prevention and surveillance of foetal growth restriction (FGR) • Element 3: Raising awareness of reduced foetal movement (RFM) • Element 4: Effective foetal monitoring during labour Work continues towards achieving compliance with all elements of the SBLCB. An independent review of the implementation across the LMS identified areas of good practice– including the adoption of best practice in reducing the incidence of cerebral palsy and good practice in identifying all smokers at their first appointment. Further developments are recommended, such as undertaking CO monitoring (to identify smokers) at additional time points in the antenatal pathway, embedding training within mandatory training schedules for midwives and standardising practice across the LMS. SBLCB version 2 was released in March 2019 and this includes a fifth element: 'reducing preterm birth'. The 3 Trusts are currently undertaking a gap analysis against the requirements of this element and will report back to the LMS Board when completed.

Maternal and Neonatal Safety Collaborative	The aim of the Maternal and Neonatal Safety Collaborative is to improve the safety and outcomes of maternal and neonatal care by providing high quality healthcare and through reducing unwarranted variation. Improvement leads from each maternity service have attended 9 days training to enable them to promote a safety culture

	within their service and to develop methods of continuous improvement in service delivery. As part of this development each service has undertaken staff training and surveys, and have implemented quality improvement projects. An in-depth 'safety culture' survey has recently been undertaken and 'de-briefing' sessions are being held within each Trust. When these are completed an LMS wide action plan will be developed to share best practice and to further embed quality improvement methods.

Continuity of Carer	Continuity of Carer (CoC) – whereby a woman has a named midwife and sees a midwife from within a team of 4 to 8 midwives throughout her maternity pathway, is a key recommendation of Better Births. National targets demand that 35% of women are booked onto a CoC pathway by 2020, with 75% of BAME groups receiving CoC by 2023/24. A number of pilots to test out how CoC can best be provided are underway across Coventry and Warwickshire. An 'at scale' pilot is being delivered in South Warwickshire (supported in part by LMS transformation monies) and smaller pilots are in Coventry and North Warwickshire. These models of care will support the provision of choices within maternity care. The expectation is that the full clinical model, with a single point of access will enable CoC to be implemented by March 2021 across the LMS, but this decision will be informed by evaluation of the pilots. The SWFT CoC pilot is being delivered out of five Family Hubs. The location of main Family Hubs were all scoped by Warwickshire County Council in their Formal Public Consultation (2018) and have been located in the areas of the highest social deprivation across the patch, all with good public transport links. These include the Lillington Children's Centre, Westgate, Kingsway, Lighthorne Health and Stratford Children's centre, supported by five satellite hubs in the more rural areas – Badger Valley, Meon Medical Centre, Alcester Children Centre and Bidford Surgery. In phase one, from a base of offering no continuity, the focus will be on offering Continuity of Carer to medically low risk women (approx. 1/3) of women. Within the demographic of low risk women, there will be women from areas of social deprivation, women with safeguarding concerns and from BAME communities, but with medically low risk pregnancies Following a full evaluation of the pilots, further roll out including women with more complexities will be offered. As midwives provide care for women throughout the pregnancy pathway; before, during and after birth it is hoped that this model will particularly benefit women from protected groups who may have language barriers and/or find it hard to build a trusting relationship with a healthcare professional/s. Midwives will be working alongside the other Health Care professionals in the Community Hubs; including family support workers, Health visitors, perinatal mental health teams which will improve the signposting and referral to other services and the overall health and wellbeing of new mothers, their babies and families. At GEH a small team of midwives (Juniper) are exploring their scope to provide continuity of carer to a cohort of women. However midwife caseloads are currently too high to allow for the necessary 24/7 coverage and therefore total intrapartum continuity cannot be achieved. The scope to increase the workforce is currently being assessed and external visits are being undertaken to learn from other areas with a view to adopting similar pathways to SWFT in future. At UHCW 4 pilots are being taken forward, as follows:

	The *complex care pilot* is aimed at those women who are classed as high obstetric need (eg requiring cardiac care or having multiple births). The initial target is to have a team of 7 midwives within this pilot to support antenatal clinics and be available for intrapartum and post-natal care. In March 2019 (the first month of implementation) a total of 36 women were booked on this pathway and for five births intrapartum continuity was achieved. The *integrated care pilot* takes a different approach to providing continuity through a team-based approach. This is based on midwives working in a in-out rotational basis. This aims to increase the likelihood that women can be cared for by their named midwife when they attend to give birth. Midwives can work in a rotational manner integrated both within maternity teams and hospital areas meaning they are familiar with all areas and can work seamlessly and actively seek the women for whom they have provided antenatal care and where there is an existing relationship. This ties into the 'staff the women rather than the building' approach, where on days allocated to hospital based care they can select the area to which they work driven by known women in the service. The *Lucina pilot* aims to capture women who chose to deliver in the midwifery-led birth centre at UHCW. If they indicate a desire to attend Lucina birth centre, then the community midwife presents the option of transferring remaining antenatal care to the birth centre staff from 36 weeks onwards. This pilot started just before March this year and the impact on continuity of carer is being monitored. The *iBumps pilot* is being delivered to the young women (<=20years) eligible for this service. The service is a city-wide service and as such works from multiple locations. Despite challenges • IBumps provided antenatal, intrapartum and postnatal care to 38.8% (21/54) of the overall cohort. • IBumps provided both antenatal and postnatal care to an additional 53.7% (29/54) of the cohort Due to iBumps being a targeted service aimed at a specific group, the team would like to develop an enhanced pathway. This involves networking and linking with other community-based services that support young women and mothers. Further development will be taken forward in light of evaluation findings.

Shared Clinical Guidelines	In total there are 36 separate clinical guidelines that need to be developed for adoption across the LMS. These have been prioritised such that those considered to have the most significant impact on maternal and perinatal outcomes are developed first. LMS-wide guidelines have been completed for • Smoking cessation • Prolonged rupture of membrane's at term • Small for gestational age/fetal growth restriction • Reduced fetal movement Work is underway to ensure the completed guidelines are implemented consistently across the LMS and further guidelines are under development.
Perinatal Mortality Reviews	Perinatal mortality accounts for the vast proportion of infant deaths and include stillbirths (after 24 weeks gestation) and deaths within the first 28 days of life (the neonatal period). The majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health, as well as congenital malformations. All neonatal deaths are reported as part of Trust specific mortality review groups with learning shared across the LMS and they are reported

	nationally. The main objective is to determine the primary and secondary causes of death and to identify possible areas where care provision can be improved. Perinatal Mortality reviews continue across the LMS. Although there has been some LMS representation at other Trusts to date, it has been agreed to ensure that representation from across the LMS is sought for each review panel. Data is to be captured in relation to this over the next 3 months and then there will be a review the impact and sustainability of this.
Learning from incidents and complaints	Local Trusts follow best practice guidance in investigating all patient safety incidents and perinatal and maternity deaths. This includes root cause analysis, examining human factors in serious incidents and learning from incidents. If any shortfalls are identified an action plan is produced to address any problems and to ensure that the safety of mothers and babies is maintained. Learning from serious incidents is shared through work stream meeting and they are also shared through the LMS newsletter.
County Wide Safety Huddle	County-wide Safety Huddles are short briefings where team leaders come together to share clinical information, review events and plan for the day ahead across disciplines and services. Huddles focus on: • sharing key general information to increase all team members' situational awareness (eg planned theatre work within each unit) • improving patient flow (eg providing details on the availability of neonatal cots) • identifying patient safety concerns, including staffing issues. Work continues towards achieving an LMS wide safety huddle for the 3 acute trusts. Equipment has been bought and a working party has been developed to implement the huddles in 2 phases.

4.3 Choice and Personalisation

The aim of this work programme is to develop potential scenarios for the future clinical model for maternity and neonatal services across Coventry and Warwickshire to ensure an integrated care pathway. The key objectives of the work programme are:

- To establish the case for change for maternity and neonatal service models to address the recommendations of the Better Birth report and neonatal transformation
- To develop and appraise the potential scenarios for the future care model
- To provide the business case for the transformation of services as required by the model design

In designing the future clinical model, the workstream is co-dependent on many of the outputs of the Quality and Safety workstream, particularly the development of the Continuity of Carer models.

Anticipated Outcomes:
The clinical model that enables choice and personalisation will ensure that:

- All pregnant women have a personalised care plan;
- All women are able to make choices about their maternity care, during pregnancy, birth and postnatally;
- Most women will receive continuity of the person caring for them during pregnancy, birth and postnatally;
- More women are able to give birth in midwifery settings (at home and in midwifery units).

The workstream is clinically driven and the main forum through which the clinical model is being developed is the 'Maternity Clinical Steering Group' (CSG), with representation on the group from both maternity and neonatal services across Coventry and Warwickshire.

The Choice and Personalisation workstream has recognised the critical interdependency between its work focus and the wider work of the STP paediatric workstream. The Maternity CSG has therefore made

reference to this wider STP programme, connecting with the work of the 'Paediatric Clinical Steering Group' as described below.

Maternity Clinical Steering Group	The Maternity CSG is overseeing a wide range of developments linked to developing options for the future overall model of care. Recent work has included: *Critical Interdependencies for Maternity* A specification for the newborn services infrastructure needed to support maternity services has been agreed and will inform the work of the Paediatric work stream of the STP. *Reducing the separation of mothers and babies:* Reducing the separation between mothers and babies has been agreed as one of the key priorities for the future clinical model. The CSG has reviewed current LMS performance against benchmarking peer groups and identified that there is scope to manage more babies care at the mother's bedside and reduce unnecessary stays in neonatal units, thereby improving the quality of care for both mothers and their babies. UHCW is achieving national exemplar levels of transitional care provision compared to its peer group. Learning from the UHCW pathway, practice and development journey has been shared across the LMS. Currently only UHCW has a designated Transitional Care unit. The further development of Transitional Care services in the LMS and development of Neonatal Outreach are therefore currently being explored to understand and test what would be required. Work to date has identified significant cost pressures associated with this development which need to be overcome before any service development plans can be put in place. The implications of developing Neonatal Outreach also need to be understood and factored into the modelling of future demand for Transitional Care in order to determine the most cost-effective and efficient clinical service for the system. *Management of High Risk/Complex Women* The processes and pathways for managing Intra-Uterine Transfers to UHCW from GEH and SWFT are being reviewed, to be brought together into one LMS-wide process. A clinical Task and Finish group is being arranged with the objective of agreeing standard operating procedures for the process through which high risk/complex women will be managed. This work will build on the existing huddle model established. *Current Choice Offer* The current provider choice offers for women have been collated to provide a baseline description of the LMS current position. Discussion on the choice offer for women has exposed that currently a significant number of women are being sent outside the LMS for fetal medicine review, that could be managed within the LMS. A clinical Task and Finish group is now being set up to identify the current gaps in fetal medicine services available locally and to specify and quantify the resources required and funding sources to enable the development of local services. *Continuity of Carer* The agreement of future service models for delivering Continuity of Carer will determine the workforce staffing models required in midwifery. The CSG is therefore monitoring and discussing the outcomes of the evaluations of the Continuity of Carer pilot programmes. The pilots are in their early stages of delivery and it is estimated

	that a further 6 months of work will be required before any assessment as to the optimum model(s) for the LMS can be made. Early indications from the pilots to date suggest that continuity delivery models need to be localised, one size does not fit all, and therefore ultimately there may not be a standardised, single LMS model.

Paediatric Clinical Steering Group	Outside the work of the LMS, the Paediatric workstream of the STP has completed a baseline assessment of the current acute general paediatric service models in place. This work has identified significant current workforce challenges across Coventry and Warwickshire and consequential issues with workload and compliance with expected service staffing and quality standards. The LMS has a link to the Paediatric Clinical Steering Group that has been established, to ensure that the work of the LMS in developing maternity and neonatal services remains in line with any development work on paediatric services, given the critical inter-dependency between paediatrics and neonates and their supporting role for maternity.

5. Underpinning Strategies

The LMS work programme is supported through a range of additional strategies and interventions including:

- Patient and public participation: each maternity service has a voluntary Maternity Engagement Group consisting of service users and professional. These local groups feed into the strategic LMS Maternity Voices Partnership (MVP). The MVP are actively involved in the design of local services and assist in the development of guidelines and in local audits of service provision. The chair of the MVP is a member of the LMS Board.
- Development of a clinical dashboard, including a range of Key Performance Indicators that reflect performance, illustrate key issues and enable comparison across services and organisations.
- Workforce planning (maternity, obstetric and paediatric)
- Development of an LMS information and technology strategy to enable the development and use of shared clinical records

The further development of Community Hubs will require an interface with both NHS and Local Authority estates strategies.

6. Conclusion

As this report demonstrates, there are multiple work programmes, supported by a wide range of multi-disciplinary / multi-agency groups. Each group requires leadership and participation from clinicians from all Trusts and sustaining the contribution of staff, who are also responsible for the delivery of clinical services, is challenging. In this context, the recommendations of this report are that the Committee:

- Notes the objectives and current work programme of the LMS
- Recognises that aspects of the work programme are yet to be addressed
- Identifies any opportunities to enable the work of the LMS to progress to the benefit of women and families across Warwickshire

7. Recommendations

The Committee comments and notes the update on Local Maternity Services

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