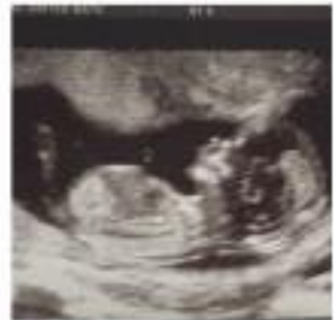

Our Local Maternity Transformation Plan

BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE LOCAL MATERNITY SYSTEM (LMS)

May 2018

Foreword

Our ambitious goal is that every woman in our region will have an equally positive experience regardless of her personal circumstance, whether she is a lone parent, a young parent supported by Family Nurse Partnership, a woman in a same sex relationship and any other pregnant woman in our diverse communities.

Birth is a special experience for all, from the women and their babies, to their partners and families through to the midwives and other birth attendants who have the privilege of being with women during this miracle of new life. This is the birth of a family too, who need to be supported so that all new parents have the confidence to take care of themselves and their new baby.

This letter reflects the care and support that we want every new mother to have. It is the unique experience of one woman, her baby and her partner.

A letter to my baby

As I watch you sleep deeply and safely, I reflect on the love I have for you and the joy you have brought me and your father.

You have had the best start in life and your dad and I have been fully supported to bring you into the world safely. We feel confident that we will be the best parents you could wish for. We thank all our carers for their support.

The health visitors continue to support us and give us information that is consistent with what we learned from our team of midwives to ensure you are developing and thriving. In partnership with my GP they also help me take care of my emotional wellbeing and knowing they are close at hand helps me feel protected, safe and confident to care for you.

Health professionals have been skilled at supporting me to nurture and sustain you by bringing you to the breast and continuing to breastfeed. Their partners in the community, such as children centres and others, are also available for us if we need extra support on our journey as new parents and to ensure we have a positive experience during this transition in our lives.

I chose your place of birth to be the safest and most relaxing place for us. During your birth, midwives enabled me to feel empowered and to be guided by my own instinct. The encouragement of family, friends and health professionals on the day gave your dad the confidence to be an amazing birth partner. Your birth felt private, safe and secure and I felt cared for, listened to and treated respectfully. I was able to follow my body's cues and make informed decisions about our care in labour and if I needed additional support, obstetricians and paediatricians were on hand.

There was much preparation leading up to your birth. I was confident in my decision about where to birth following open and informed discussion with my midwife. There were also opportunities for your dad to be involved in this. During my pregnancy with you I felt your movement, we talked about it at my antenatal checks, and my team of midwives measured and prodded me to check you were developing properly. I felt cared for, and as parents to be, contact with our midwifery team and antenatal classes prepared us for your birth and parenthood. We also built a social network along the way meeting other new parents.

When your dad and I felt ready for new beginnings, we prepared ourselves for conception, ensuring we were as healthy as possible and able to give you the best start in life.

Those nine months of us being together as one were an unforgettable journey as you developed from an egg to an infant. I look forward to our life as a family and feel blessed that we have received the best care possible.

Forever Yours

A New Mother

This is an exciting time for our maternity services and for women and families in B&NES, Wiltshire and Swindon. Service user representatives have been centrally involved in developing our local transformation plan, working alongside key stakeholders, sharing information, considering needs, identifying gaps and shaping services that have women and their families at the centre.

We begin this transformation from a strong base with well-established relationships across the local maternity system (LMS); good engagement from all parties; and a shared passion and commitment from all stakeholders to change our services for the better. It is now time to put our well thought out plans into action and drive forward our vision for "all women to have a safe and positive birth and maternity experience and to be prepared to approach parenting with confidence."

Trudi Webber (MSLC Vice Chair) on behalf of service users

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Introduction

Bath and North East Somerset, Swindon and Wiltshire (BSW) maternity services have increasingly been working together to improve services for women. Strong relationships have developed between the three hospital Trusts and commissioners. We welcome the publication of “Better Births, Improving outcomes of Maternity Services in England” as it provides a vision and framework for us to progress. The national blueprint for maternity as described in the Five Year Forward View has also been used to form this plan.

The providers and commissioners within BSW are active participants in the South West Maternity Clinical Network, which benchmarks providers and facilitates quality improvement initiatives. We are well placed to build on the success of this established network to transform our local maternity services through clinical leadership.

We will proactively engage with women, fathers, families and communities to ensure safe births, positive experiences and equity for all women. As organisational boundaries blur, staff and services will be enabled to improve communication and continuity of care. We will work together with partner agencies to develop seamless pathways that enable women and their families to access services to further enhance their physical, emotional and mental health in pregnancy and support the transition to parenthood ensuring the best possible start for babies.

We recognise that the commitment and ideas from staff provide the foundation of any transformation and we will ensure that their feedback informs and shapes our plan as it develops. Through embedding a continuous quality improvement approach, we will further develop the existing safety culture that is evidenced by transparent reporting and sharing of learning from serious incidents. We are committed to sharing and learning from each other when things go wrong as well as when celebrating success.

The current national pilot projects underway will provide additional learning and guidance which we are keen to adapt for our Local Maternity System as the evidence becomes available. This is an exciting time for maternity services in England, and we are looking forward to not only implementing our local plan but also being part of the country wide transformation that aims to make maternity care amongst the best in the world.

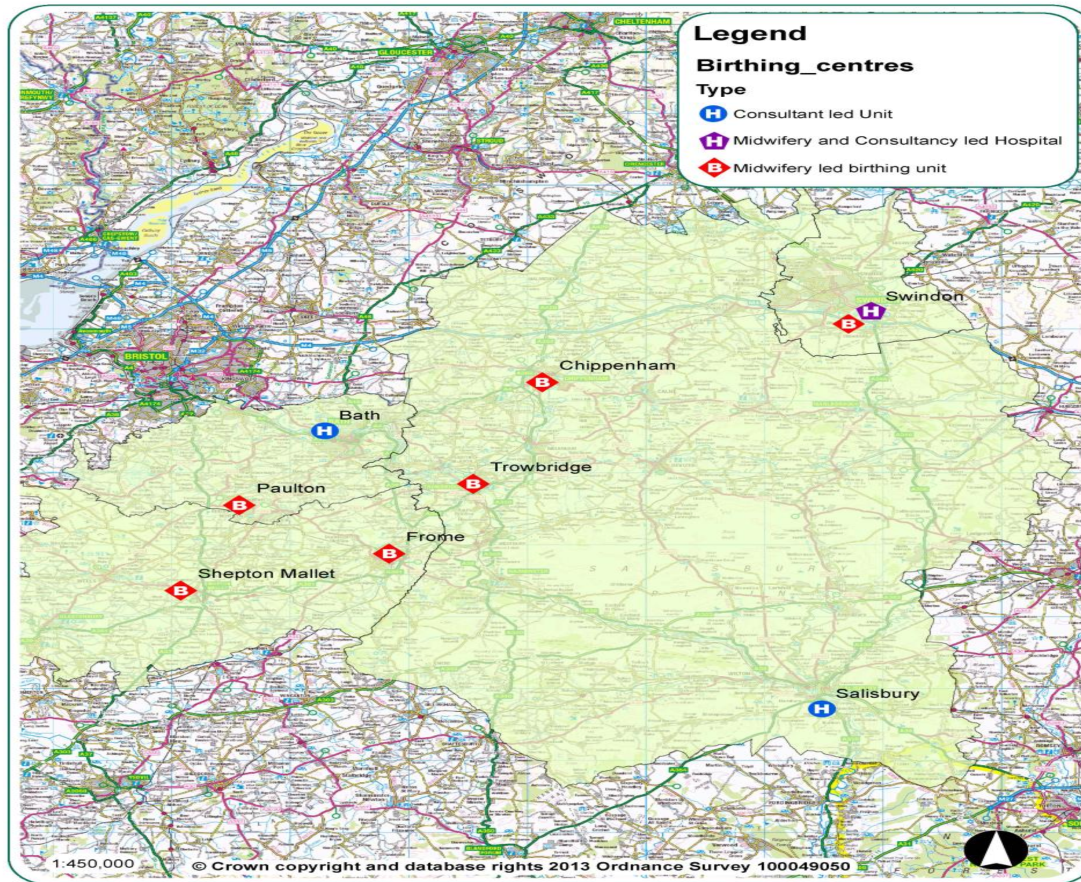
1. Our Local Maternity System

A Local Maternity System (LMS) has been created across the Bath and North East Somerset, Swindon and Wiltshire (BSW) Strategic Transformation Partnership (STP) footprint. The LMS is hosted by Wiltshire Clinical Commissioning Group (CCG) and includes service users and all providers and commissioners across the maternity pathway.

Our LMS has an extremely varied demographic structure and geography, which poses challenges to the delivery of maternity services. It features large rural areas (particularly the mid-Wiltshire Salisbury plain area) as well as urban centres. The main acute providers and larger towns are located on the periphery of the STP footprint. The footprint incorporates a largely affluent population but there are pockets of deprivation (6.4% of the population falls within the most deprived quintile).

The maps below detail birthing locations across the LMS.

Map 1: Birthing locations as per 2013*



**Note: Shepton Mallet now provides antenatal and postnatal care only.*

Map 2: Better Births Initiatives Mapping – Live birth density:

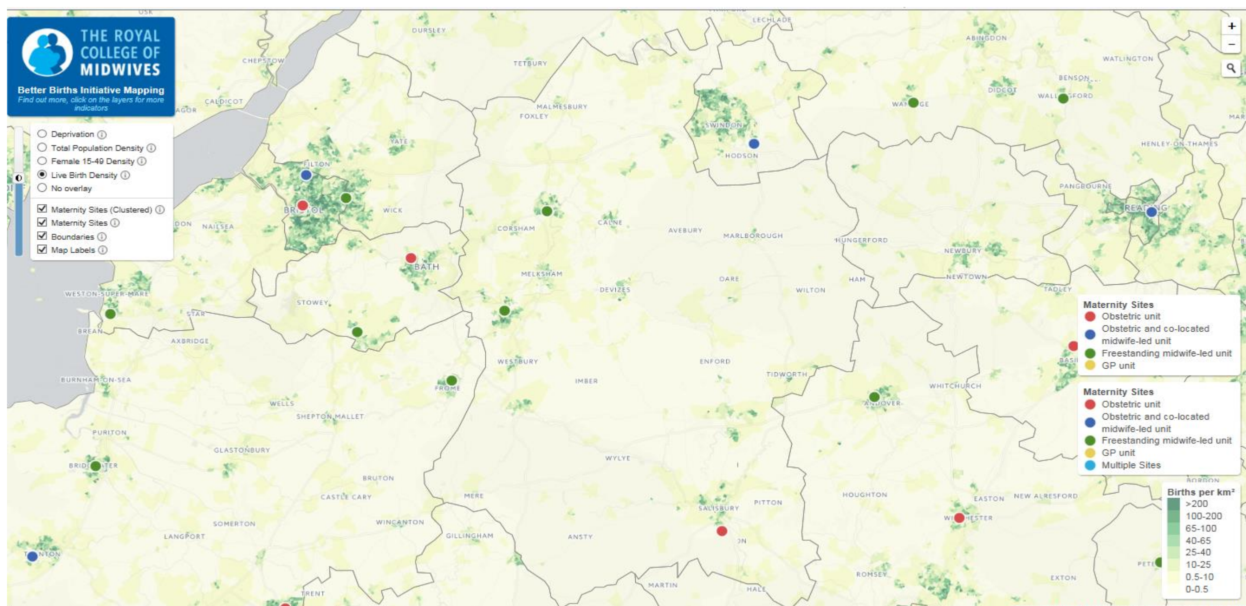
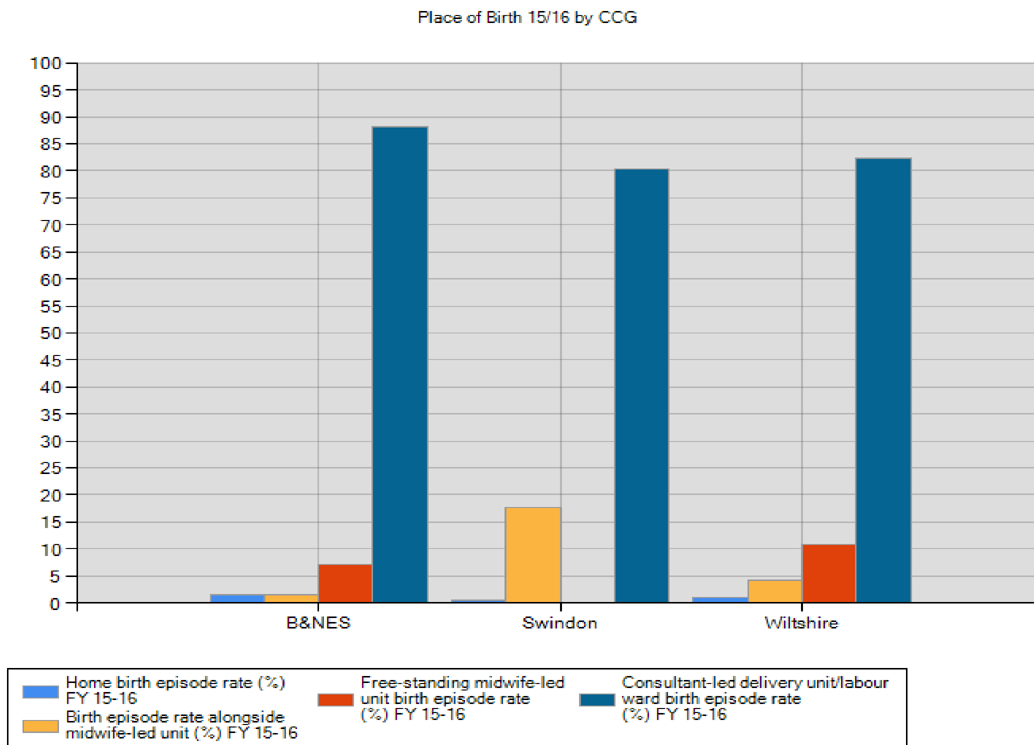


Table 1: Current maternity provision across the STP footprint:

Organisation	Maternity care and birth provision				
	Antenatal and postnatal care	Hospital based consultant care	Home birth	Standalone birth centre	Co-located birth centre
Royal United Hospitals Bath NHS Foundation Trust	√	√	√	Trowbridge Chippenham Frome Paulton	
Great Western Hospitals NHS Foundation Trust	√	√	√		√
Salisbury Hospitals NHS Foundation Trust	√	√	√		

Salisbury are currently exploring the option of a co-located birthing unit linked to military repatriation and associated demographic growth. It is our vision that all women will have access to the full range of antenatal, postnatal and birth choice options across the LMS footprint. An acute services redesign process has been commenced to review current choice and develop future options, which will be subject to a full public consultation exercise. Further details of this process feature in section 5.1. The maternity provision naturally affects the choices women make around where they birth. Figure 1 below illustrates this variation across the LMS.

Figure 1: Place of Birth 15/16 by Clinical Commissioning Group



Source: SWSCN

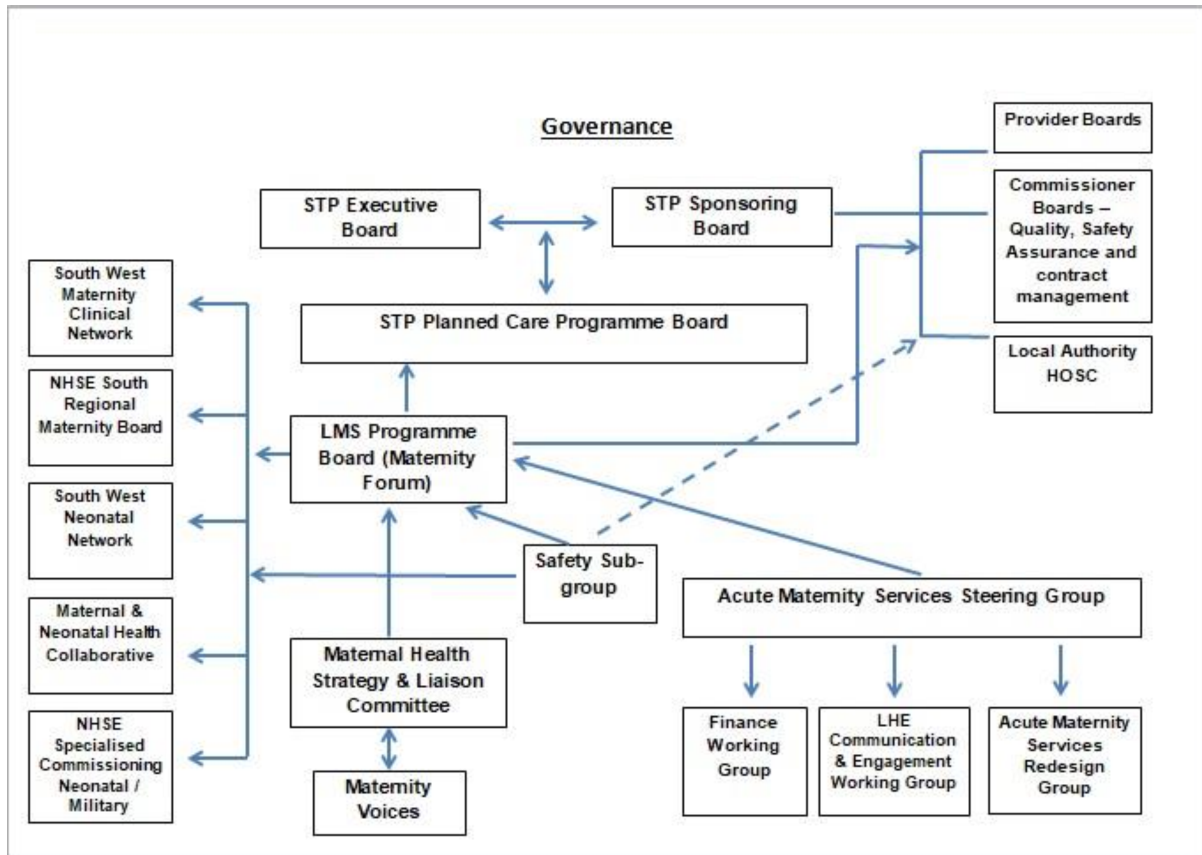
2.1 Governance

The Local Maternity System (LMS) consists of the Local Maternity System Programme Board and the Maternal Health strategy and Liaison Committee. The LMS Programme Board is the overarching group that monitors delivery of the maternity transformation agenda. The Maternal Health Strategy and Liaison Committee (MSLC) is the multi-disciplinary arm of the LMS that influences the strategic direction of the maternal care pathway across early year's services. It is chaired by Public Health and is attended by a range of stakeholders including service users (See Appendix 1 for core membership). Ensuring providers and commissioners take account of the views and experiences of women and their families who use maternity services is a key function of the group.

Maternity services are commissioned by B&NES, Swindon and Wiltshire CCGS and quality and safety assurance is provided through CCG Contract Quality Review meetings and processes. Maternity measures are included in the CCG Internal Assurance Framework (IAF). This data is reviewed at the LMS Programme Board. The LMS has strong links into the South West Clinical Network and the NHS Improvement maternity and neonatal safety collaborative.

A dedicated Acute Maternity Services Steering Group has been created to support the service reconfiguration aspects of our choice work stream. This is supported by finance, redesign and communication and engagement working groups. Further detail can be found on page 21.

Fig 2: The LMS Governance framework



Our LMS Programme Board has the following membership which features in the table below:

SRO	Chief Officer, Wiltshire CCG
Programme Director Lead Commissioner	Director, Wiltshire CCG
STP/ LMS lead midwife	Head of Midwifery, SFT
STP / LMS lead public health representative	Wiltshire Council
Senior representation (Clinical and managerial)	All Acute Provider
Project Midwife	LMS
Lead Consultant	RUH/SFT/GWH
Lead GP	B&NES CCG
Quality lead	Associate Director of Quality, Wiltshire CCG
Finance lead	Deputy Chief Finance Officer, Wiltshire CCG
Comms and engagement lead	RUH/ WCCG
CCG representation	Swindon and B&NES

Maternity Voice Partnerships

The BSW LMS was successful in its bid for national monies to support the development of a local Maternity Voices Partnership. It is envisaged that a local maternity voice partnership will be set up in each provider area.

Plan for Maternity Voice Partnerships:

- To ensure that the voices of parents and service users along with staff continue to inform the development of services both now and in the future.
- To ensure that the MVP work feeds directly into the BSW LMS to shape commissioning of services.
- To ensure the service user voice is representative and includes the voice of women who may need additional support such as those experiencing poor perinatal mental health; young parents; those with a cultural difference and so on.
- To develop a sustainable model of service user engagement.
- To continue to review and co-create pathways to deliver the transformation agenda and improved services and experiences in line with our Maternity Transformation Plan vision.
- By end of April 18: agree plans and funding within LMS.
- By end of June 18: Recruitment of 6 members from groups in place.
- By end of July 18: Co-production of engagement strategy to go to LMS.
- By end of August 18: Set dates for Participatory Appraisal training. Start communications with wider public.
- By end of October 18: Schedule of feedback agreed.
- By end of December 18: work streams in place and feedback obtained by participatory appraisal methodology.
- End of February 19: feedback to the LMS to influence commissioning for 19/20.

2.2 The LMS and Accountable Care Organisations

Accountable care is about bringing organisations in an defined area together to work towards a common goal of helping the local population to live healthy, independent lives in which the right health and social care is available when needed.

Providers and commissioners are being encouraged to join forces in a way that will enable woman and their families to access, and staff to provide, care that is more integrated and free from the organisational barriers that can often cause delay, confusion and frustration to many. The organisations will include local councils, health care providers and social services.

Sustainability and Transformation Partnerships (STP) will need to co-ordinate with the Accountable Care Organisations within their area to influence the agenda. Our plans have been presented and signed off by the Executive BSW STP Board.

Co–design approach to identifying key streams and priorities including engagement events with staff and service users will set priorities for areas of focus relevant to the needs of the population that the Accountable Care Organisation covers.

The LMS will liaise closely with neighbouring Accountable Care Organisations and STPs to ensure that priorities are shared and discussed to ensure the maternity agenda has influence and a voice.

3. An understanding of the local population and its needs for maternity services

It has not been feasible within the time limitations to conduct a full maternal health needs assessment across the LMS to inform this plan. Nevertheless, all available data has been reviewed from a range of sources including Public Health England, the South West Clinical Network Maternity Dashboard and RightCare, ONS data and some conclusions drawn.

3.1 Geography and population

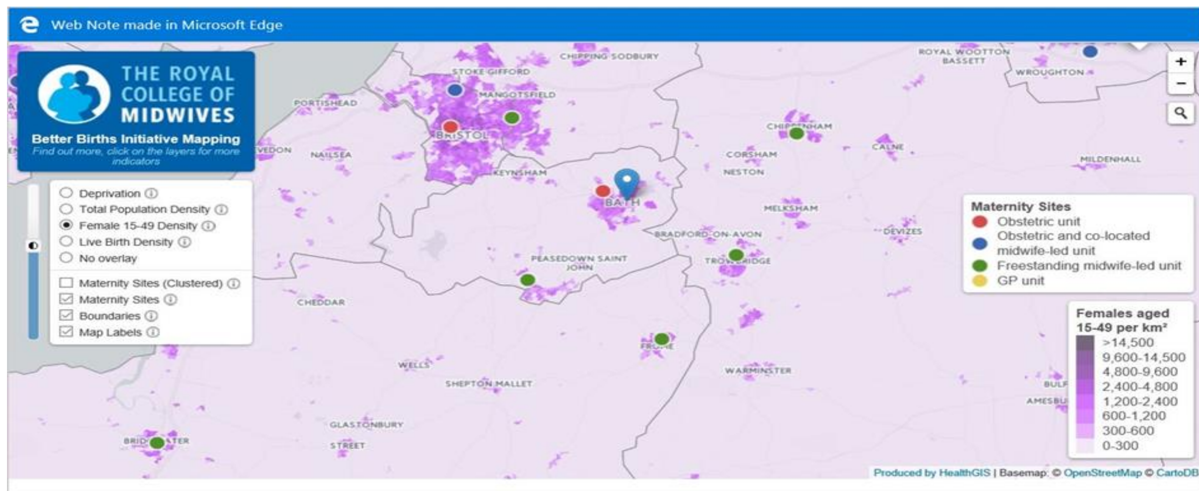
Wiltshire, Swindon and B&NES span a large geographical area of 3,875 km^2 with a total population of 894,065 based on ONS 2016 mid-year estimates. Each area has distinctively different geographies and demographics which are important to consider when transforming maternity services locally.

Wiltshire is a predominantly rural area covering an area of 3,485 km^2. and population density averages 140 people per km^2. It is largely white-British population with few people from ethnic minorities. Access to maternity services varies considerably for women living in different parts of Wiltshire.

Swindon is a large town covering an area of only 40 km^2 and the average population density is 5,447 people per km^2. The 2011 Census showed population growth to be faster in Swindon than the England average and the population from minority ethnic groups nearly doubled in ten years. B&NES area contrasts greatly in terms of density and diversity of population. The City of Bath accounts for approximately half the population and is 12 times more densely populated that the remainder of North East Somerset. About 10% of the population are non-white-British. In terms of deprivation B&NES is one of the least deprived authorities in the country, ranking 247 out of 326.

The density of female population aged 15 to 49 is reflected in map 3 below. The LMS will undertake further work to analyse the data that informs the map and consider the implications.

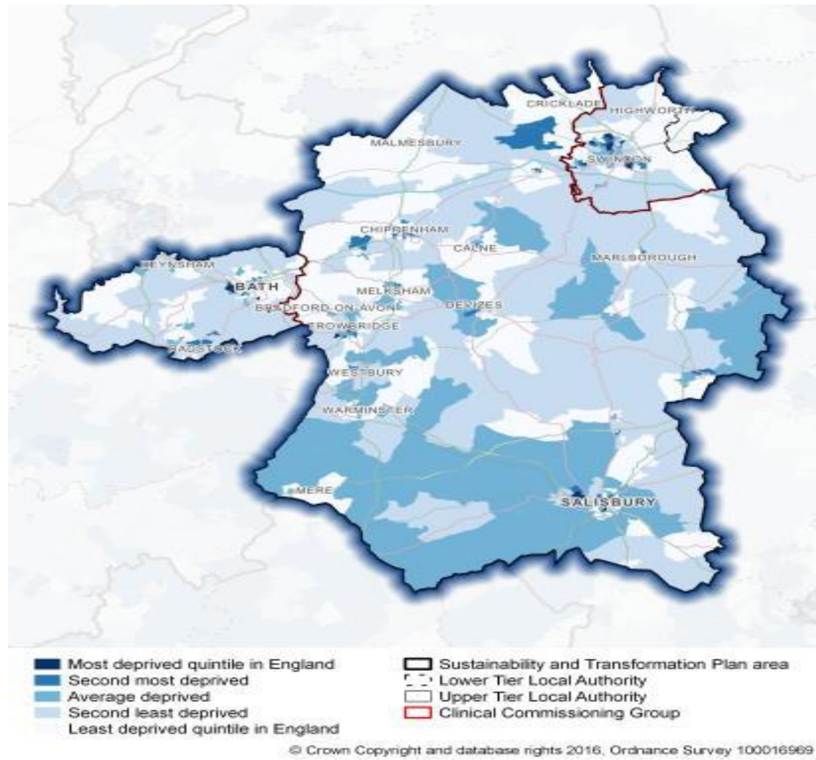
Map 3: Better Births Initiative Mapping – Female 15-49 Density



3.2 Deprivation

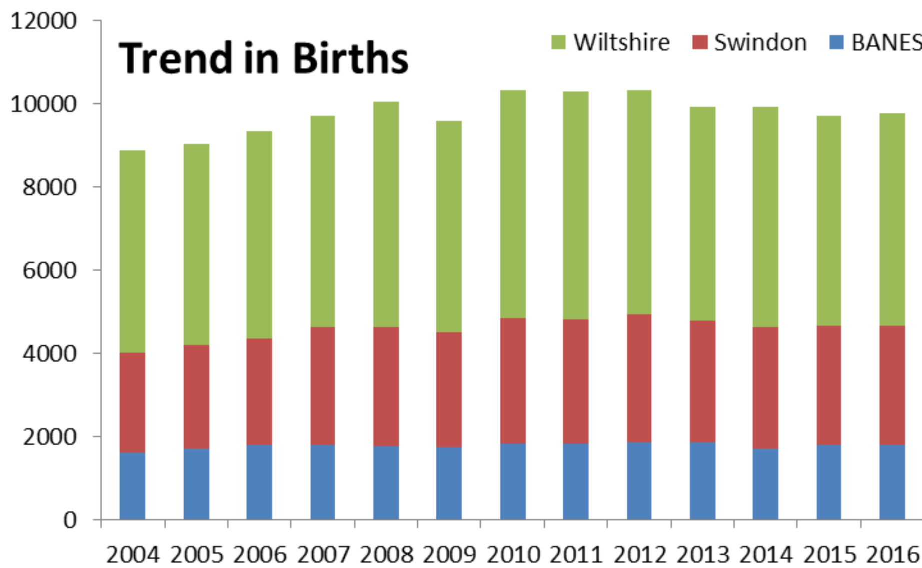
The Index of Multiple Deprivation (IMD) ranks the 32,844 Lower Super Output Areas (LSOAs) in England in terms of deprivation. LSOAs contain about 1,500 people. Wiltshire and B&NES are considered to be generally prosperous areas; however, there are hidden pockets of deprivation as illustrated in Map 4. Based on 2015 IMD data, 12 LSOAs in Wiltshire are within the 20% most deprived LSOAs in England and five in B&NES. Deprivation is more evident in Swindon with 19 LSOAs within the 20% most deprived nationally and eight of those are in the 10% most deprived.

Map 4: Deprivation quintile map 2016



3.3 Number of live births

Over the last 12 years there has been some variation in the overall number of births with a low of just under 9,000 in 2004 to a high of over 10,300 in 2012. There has been little variation, however, in the proportion of births in each of the three areas during the same period (Figure 3). Most recently (2015), just over half the births were to women who lived in Wiltshire (53%), just under a fifth were to women who lived in B&NES (18%), and just under a third were to women who lived in Swindon (29%).**Fig 3: Trend in Live Births**



Source: ONS

Although the number of births in each area has fallen slightly in recent years (Table 2), the latest ONS projections forecast a gradual increase in the number of births for each area. Local policy-led projections sometimes present a different picture (Figure 4). Swindon Borough Council's policy-led projection forecast a slightly bigger rise in Swindon births. In Wiltshire, a combination of plans to increase housing, as set out in the Core Strategy, and the army rebasing programme are expected to impact on birth numbers. An initial crude estimate suggests this could result in over 700 additional births across Wiltshire. The LMS recognise the importance of closely monitoring population changes to ensure the vision outlined in this MTP can be delivered effectively.

Table 2: Number of live births by local authority

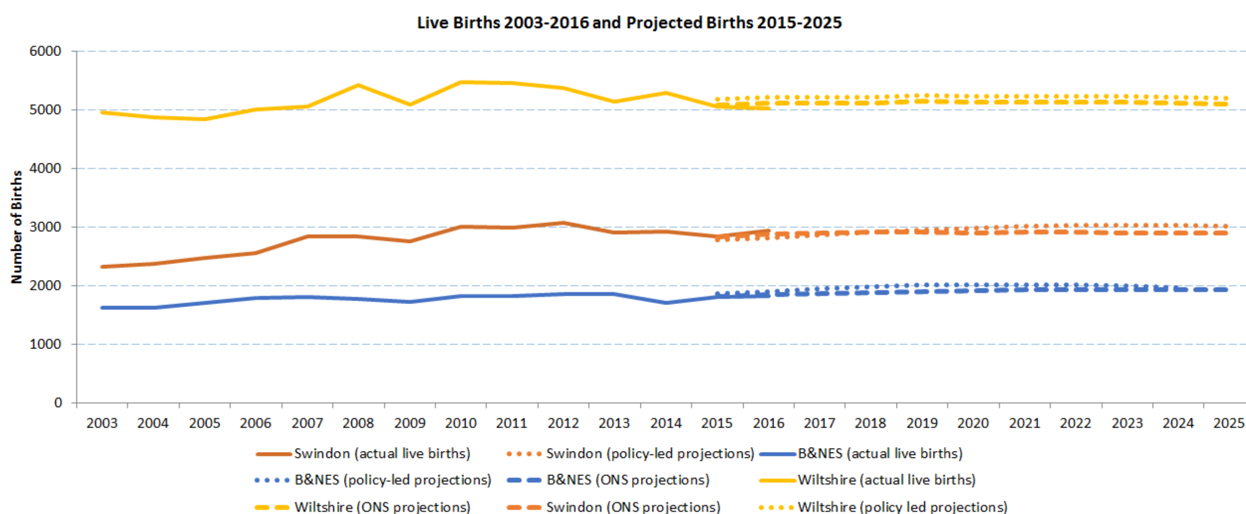
	Births			
	BANES	**Swindon**	**Wiltshire**	**LMS total**
2012	1867	3073	5378	10318
2013	1854	2911	5133	8044
2014	1702	2923	5290	9915
2015	1808	2847	5050	9705
2016	1799	2848	5119	9766

Table source: ONS

Figure 4 illustrates the following birth projections for our footprint working from a baseline of 9,790 births

- 2018/19 - 10,127
- 2019/20 - 10,213
- 2020/21 - 10,238

Figure 4: Projected number of births



Source: ONS, BANES, Wiltshire and Swindon Borough Councils

3.4 Early booking

It is recommended that women have access to maternity services for a full health needs assessment ideally by 10 weeks of pregnancy (NICE, 2008). Late booking and late access to antenatal care is a known risk factor. In B&NES, Swindon and Wiltshire ≥90% of women book early in pregnancy in comparison with the South West median is 92%.

3.5 Flu vaccination in pregnancy

The Public Health England influenza immunisation programme aims to offer protection to those who are most at risk of serious illness or death should they develop influenza. Preventing flu in pregnancy plays an important part in preventing maternal deaths (MBRRACE, 2014).

Table 3 provides data on flu vaccination uptake in pregnancy and shows a small increase across the LMS in 2016/17 compared with 2015/16. Increasing the uptake flu vaccinations in pregnant women is a priority for the LMS and flu clinics were introduced in some maternity services across the footprint in 2016/17 as a pilot approach. All maternity services have repeated this model for the 2017/18 flu season. Improved access for pregnant woman at scheduled screening appointments commenced in October 2017.

Table 3: Provisional cumulative uptake data for England for vaccinations in pregnancy given from 1 September 2016 to 31 January 2017

Flu vaccine in pregnancy uptake data		
Local Authority	**2016-17**	**2017-18 (provisional)**
Bath and North East Somerset	45.7	53.9
Swindon	47.1	51.2
Wiltshire	44.0	51.5
England	44.9	47.2

source: PHE - https://www.gov.uk/government/collections/vaccine-uptake#seasonal-flu-vaccine-uptake:-data-collection-guidance. Published 9 January 2018

The national expectation is to deliver flu vaccinations to 75% of the pregnant population therefore further work is required to achieve this.

3.6 Complex needs

The following risk factors are known to increase a mother and baby's vulnerability to adverse events: booking late in pregnancy (early booking data is routinely collected to monitor this); maternal age where risks are higher for younger women and older women; language barriers; smoking in pregnancy; obesity in pregnancy; maternal mental health; multiple births. Data related to these risk factors is presented in Table 4 with the exception of maternal mental health for which robust data is not yet available.

Table 4 Women with complex needs by pregnancy by CCG area 2016/2017

Women with complex needs in pregnancy by CCG area

	Swindon	B&NES	Wiltshire	South West median
Early booking in pregnancy (2016-17) (1)	92.2%	93.9%	94.5%	92.2%
Birth rate from under 18 conceptions (2016-17) (1)	1.1%	0.6%	1.1%	1.1%
Birth rate in women aged 40 or over 2016-17 (1)	2%	3.5%	3.4%	2.8%
% of babies born to mothers born in the Middle East and Asia (2014) (2)	10.5%	3.2%	2.7%	3.3%
Smoking at birth rate (2016-17) (1)	10.9%	6.9%	9.5%	11%
Obesity - BMI≥30 (2016-17) (1)	21.9%	16.5%	22.7%	21.8%
Multiple births per 1000 (2015) (2)	20.4%	14.5%	14.2%	14.9%

Source: (1) South West Clinical Network Maternity Dashboard 2016-17 / (2) PHE Public Health profiles

Breastfeeding initiation by CCG area (2014-15 to 2016/17)

	1415 (1)	1516 (2)	1617 (2)
Swindon	84.1%	84.4%	79.2%
B&NES	76.3%	84.4%	85.9%
Wiltshire	80.1%	76.3%	74.4%*
South West	79%	77.4% (median)	78.1% (median)
England	74.3%	n/a	n/a

*Source: (1) DH statistical releases / (2) South West Clinical Network Maternity Dashboard / *affected by data quality issues*

Wiltshire has a higher percentage of women over 40 years birthing than in the other areas, but not exceptionally high for the South West. The difference in ethnicity of mothers is very apparent in Swindon with over 10% of babies born to mothers from the Middle East and Asia, reflecting the greater ethnic diversity in Swindon. Smoking rates are highest in Swindon and lowest in B&NES which may be related to levels of deprivation in the respective areas. Maternal obesity is lowest in B&NES and similar to the South West median in both Wiltshire and Swindon. Swindon has a notably higher rate of multiple births than B&NES and Wiltshire.

RightCare Maternity and Early Years data comparing Wiltshire, Swindon and B&NES each with their 10 most demographically similar CCGs also highlights smoking in pregnancy as an area of

‘opportunity’ for improvement. Overweight and obesity rates in children aged 4-5 are also notably high compared with demographically similar CCGs suggesting there is opportunity for improvement. Babies born to obese mothers are at greater risk of becoming obese children which highlights the importance of working to ensure women adopt healthy lifestyles before and during pregnancy and to support and enable more women to breastfeed. The RightCare data for all CCGs within the LMS was presented and discussed at the Maternity Forum on Thursday 25 May 2017 and the above priorities identified.

The LMS Programme Board will be reviewing complexity data during quarter three 2018 to establish a baseline which will be used to aid future planning and service requirements. This will include complexity classification as used in Maternity Pathway Payments and complex social needs.

3.7 Perinatal mental health

Perinatal mental illness refers to a range of mental health problems of varying severity that can affect women during pregnancy and in the year after birth including anxiety, depression and postnatal psychotic disorders. Such problems affect up to 20% of women at some point during pregnancy and for the first year after birth and can have a significant negative impact on the mother, family and her developing child. Mental illness is one of the leading causes of maternal death in the UK and the number of new mothers committing suicide has not fallen over the past decade. Babies born to mothers experiencing perinatal mental health illness are at increased risk of prematurity, low birth weight, infant mortality, suboptimal growth, illnesses, neurodevelopmental problems and long-term cognitive outcomes.

Table 5 provides an estimate of perinatal mental illness across the LMS broken down by area and shows the potentially large numbers of women to suffer from mild to moderate mental illness during the perinatal period. Research indicates that there will also be a proportion of fathers who develop mental health difficulties during this period.

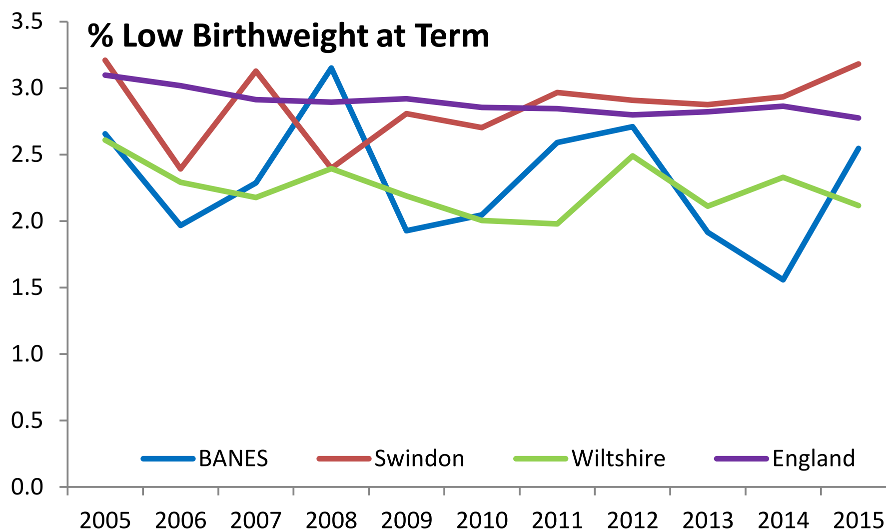
Table 5: Perinatal Mental Health Projections taken from the Chi Mat tool

Perinatal Mental Health Projections	NHS Wiltshire	NHS B&NES	NHS Swindon
Estimated number of women with postpartum psychosis (2013/14)	10	5	10
Estimated number of women with chronic SMI (2013/14)	10	5	10
Estimated number of women with severe depressive illness (2013/14)	140	55	90
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate) (2013/14)	460	180	290
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate) (2013/14)	685	270	435
Estimated number of women with PTSD (2013/14)	140	55	90
Estimated number of women with adjustment disorders and distress (lower estimate) (2013/14)	685	270	435
Estimated number of women with adjustment disorders and distress (upper estimate) (2013/14)	1,370	540	865

3.8 Low birth weight babies

Low birth weight (babies born weighing less than 2.5kg) is a major determinant of mortality, morbidity and disability in infancy and childhood and also has a long-term impact on health outcomes in childhood and adult life. Low birth weight of full term babies is obviously of most concern and routinely monitored. Figure 5 shows the trend across the LMS and compares with England.

Figure 5: Trend in percentage of low birth weight at term babies



Source: ChiMat

The average percentage of low birth weight babies at term has been falling in England as has the percentage in both Wiltshire and B&NES. In Swindon the percentage has been rising and is now higher than the England average.

3.9 Caesarean births

Unnecessary caesarean (not medically indicated) births carry additional risk of complication to both the mother and baby as well as increased health care costs. The latest data available locally (Table 6) shows the percentage of caesarean births broken down by NHS Trust and by CCG area in 2016-17. The data ranges from 22.9% at the Royal United Hospital NHS Foundation Trust, significantly lower than the South West median of 24.9%, to 27.6% at the Great Western Hospital NHS Foundation Trust, significantly higher than the South West median.

Table 6: Caesarean births rates by NHS Trust and CCG area (2016-17)

	Caesarean birth (1)
NHS Trust	
Royal United Hospitals Bath NHS Foundation Trust	22.9%
Great Western Hospitals NHS Foundation Trust	27.6%
Salisbury Hospitals NHS Foundation Trust	23.1%
CCG	
B&NES	Data not available
Swindon	27.6%
Wiltshire	23.6%
South West median	24.9%

Source: (1) South West Clinical Network Maternity Dashboard

Work has commenced across the LMS to explore caesarean birth rates. This includes a dedicated research project at GWH being supported by the University of West of England.

3.10 Breastfeeding

Breastfeeding reduces the risk of infant infection and mortality and confers protection for the mother from breast cancer. There is also some evidence that breastfed babies have lower incidence of Sudden Infant Death Syndrome (SIDS), are less likely to be obese as children and have a higher IQ. Table 7 shows the latest annual data and a more up to date snapshot from the regional maternity dashboard.

Table 7: Breastfeeding initiation by area

Breastfeeding initiation by area	Breastfeeding initiation		
	1415 (1)	**1516 (2)**	**1617 (2)**
Swindon	84.1%	84.4%	79.2%
B&NES	76.3%	84.4%	85.9%
Wiltshire	80.1%	76.3%*	74.4%*
South West	79%	77.4% (median)	77.9% (median)
England	74.3%	n/a	n/a

*Source: (1) Department of Health Statistical releases / (2) South West Clinical Network Maternity Dashboard / *affected by data quality issues*

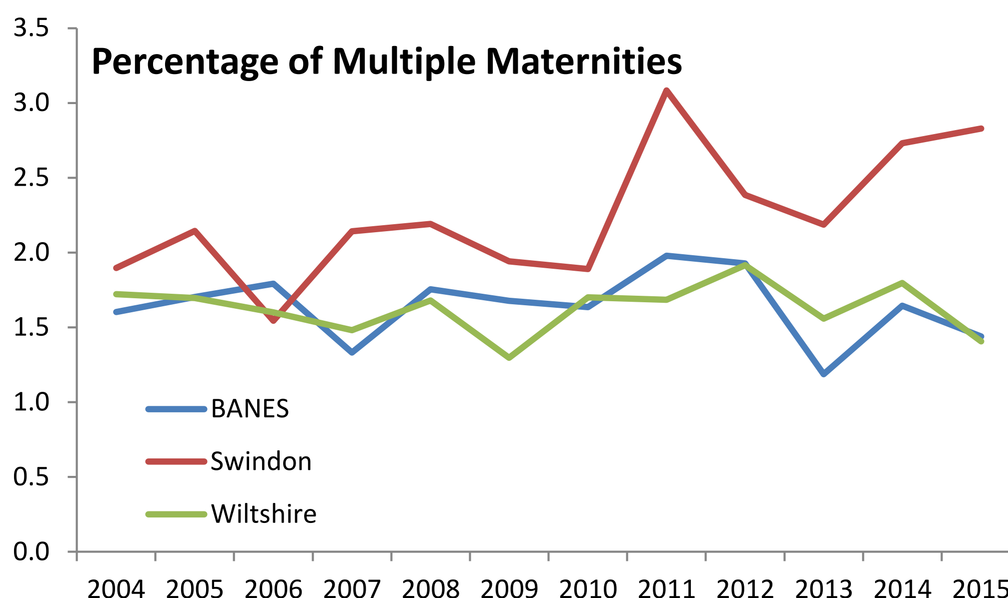
Breastfeeding initiation rates in Swindon, B&NES and Wiltshire have been higher than the national and regional averages for many years. This continues to be the case although data quality issues have affected the ability to monitor progress accurately over the last 12 months.

However, a closer look at the data reveals variation in relation to age and deprivation. Breastfeeding initiation rates are lower in more deprived areas and breastfeeding initiation among young mothers (under 25 years of age) is statistically significantly lower than any other age group.

Despite a high percentage of women initiating breastfeeding, historic data suggests that many women cease breastfeeding in the early weeks. Due to changes in the way 6-8 week breastfeeding data is collected recent data quality is variable across the LMS and, therefore, not included. As data quality improves breastfeeding drop-off rates will be monitored and analysed to ensure women are being supported to sustain breastfeeding.

3.11 Multiple births

Figure 6: Trend in multiple births which carry risks for both the mother and baby



Source: ONS Vital Statistics

The trend for both B&NES and Wiltshire is generally consistent and the same. The trend in Swindon is increasing and is now higher than both B&NES and Wiltshire. This may be linked to increasing numbers of fertility treatments and associated potential percentage of multiple births.

3.12 Infant mortality and stillbirth

Wiltshire, Swindon and B&NES MSLC maintains regular oversight and scrutiny of infant mortality and stillbirth data to enable it to fulfil its key function of ensuring maternity care is of the highest quality. Infant mortality is well recognised as an indicator of population health; the wellbeing of infants, children and pregnant women; and of progress towards addressing inequalities. Most infant deaths occur in the first 27 days of life and stillbirths and infant deaths are associated with a number of complex risk factors, including obesity, smoking, maternal age and inequalities.

It is well recognised that many of the risk factors that impact on low birth weight, infant mortality and stillbirth are disproportionately represented in the most deprived communities. Local data supports this.

The Wiltshire, Swindon and B&NES Stillbirth and Infant Mortality Report (2017) looked in detail at births, stillbirths, perinatal and infant mortality across the LMS and associated risk factors over the last ten years. In summary:

- **Infant mortality rates** in B&NES and Swindon are reducing across the STP.
- The **stillbirth rates** are broadly similar in all areas although the trends vary. There is an upward trend in B&NES, a downward trend in Swindon and a fairly consistent trend in Wiltshire.

The stillbirth baseline rate is 5.6 per 1000 which is estimated to reduce to 5 per 1000 (2019), 4.8 (19/20), 4.6 (20/21). Further information on stillbirth and neonatal death actions feature in section

Perinatal mortality rates are similar for all areas. The trend in Swindon is reducing; for B&NES and Wiltshire the trend is flat.

3.13 Key Challenges

Based on the factors set out in this section, the key challenges facing the LMS are as follows:

- Improve maternal nutrition and reduce maternal obesity levels.
- Reduce smoking in pregnancy to 6% by 2022.
- Increase the uptake of the flu in pregnancy vaccination to better protect women.
- Increase breastfeeding rates with a particular focus on young mothers and those from more deprived communities.
- Maintain implementation of the NHSE *Saving Babies' Lives* care bundle and monitor progress.
- Improve the care pathway for women with maternal mental health difficulties, including those with chronic low-level problems.
- Developing continuity of carer and appropriate staffing levels in the context of a rising birth rate and increasing complexity within existing resources.
- Managing the expectations of staff, service users, their families and communities.
- Ensure equity of maternity provision across the LMS whilst ensuring services are able to respond to demographic variations and the differing needs of the population.
- Ensure we have sustainable workforce across our system with robust planning.
- Ensure we continue to consult and co-create our vision and future delivery of our services with our population.
- Ensure we balance improving the overall health of the maternal population with targeting interventions effectively to address the health inequalities that exist.

4.0 The views of women

In April 2017 Public Health professionals worked together with service user representatives from the MSLC to develop and implement an online Place of Birth Survey. The survey focussed on what and/or who informs women's decision about where to birth their baby and was targeted at women who were currently pregnant and those who had given birth within the last year. The week long survey received 850 responses.

The respondents were from a fairly representative sample in terms of deprivation and there was a 50:50 split between those pregnant and those who had given birth in the last 12 months. The data was analysed, themes drawn out and the following recommendations made:

- Develop ways of engaging with partners and ensuring they have access to unbiased information to inform decision making around place of birth.

- Ensure unbiased information and discussion that includes the risks and benefits of all birthing options is offered to all expectant parents consistently across the Local Maternity System. To include identifying and agreeing use of an online tool, e.g. Which Choices.

- Actively promote positive birth stories and experiences to expectant parents and the wider community to promote positive birthing generally and to help break down misconceptions about certain birthing choices, such as birthing in the community.

- Engage with service users to gain a more detailed and deeper understanding of what aspects of birth environment affect their decision about where to birth.

- Adopt a similar methodology in the future to gather feedback from a representative sample of service users on issues related to maternal health and care.

Maternity services have a variety of tools to gather patient experience and feedback including Friends and Family Test (FFT), CQC Maternity Picker Survey, Birth Reflections, Compliments and Complaints. This information is regularly triangulated to gather themes, both positive and areas for improvement, to ensure priorities align with what our women and their families are telling us.

Local themes include:

- Quality of care – kindness, compassion, listening.
- Continuity of Carer – antenatal and postnatal.
- Better communication between teams / other health professionals.
- Emotional wellbeing and support in the post-natal period.

There are clear similarities to the national picture and the priorities of Better Births: Safer Care, Personalised Care, and Continuity of Carer, Working across boundaries, Multi-professional working and Better Postnatal and Perinatal Mental Healthcare (Better Births). All maternity services have facilitated or are planning to run ‘Whose Shoes’ workshops. The word cloud below features an example from one of our Trust’s.

5.0 Better Births Gap Analysis

All maternity providers completed a self-assessment against the Better Births recommendations. These assessments were reviewed at the MSLC and common themes drawn together to help shape the priorities of this transformation plan.

Themes from the 'Better Births' analysis from 2016

There are seven areas that each provider within the B&NES, Swindon and Wiltshire LMS measured themselves against. This self-assessment was formulated as a GAP analysis.

Red – unlikely to achieve this recommendation without significant investment or service transformation, which has not yet been agreed.

Amber – have a good possibility of achieving this recommendation within the national time-frame.

Green – already meet this recommendation or can realistically achieve it by March 2017.

Table 8: Themes from the 'Better Births' analysis from 2016

Work stream	Positives	Challenges	Overall RAG rating
Personalised care and choice	All 3 providers currently looking at ways of giving unbiased information	• 2 providers have 3 out of 4 birth place choices. • Personalised plans not fully implemented.	Red
Continuity of Carer	In some areas there is evidence of continuity of in the antenatal period	• All providers have a high number of midwives that have chosen to work part time. • None of the three maternity services have continuity within the maternity workforces.	Red
Better Postnatal and perinatal mental healthcare	Perinatal infant mental health pathway is being developed across the LMS footprint and all providers are engaged with this development	• Post natal care provision is patchy and there is little consistency in the post natal offer. • There is a variation in availability of community mental health services.	Amber
Working across boundaries	All providers are involved with local systems- MSLC and planned maternity forum	• There are no shared policies and pathways between the providers. • Digital systems are not compatible between providers. • Community hubs are not yet a consideration.	Amber
Safer care	All providers site a culture of learning and continuous improvement Duty of Candour in place in all organisations All providers are signed up to the National Maternity and Neonatal Health safety Collaborative	The rapid redress scheme is an expectation but this has not been outlined nationally	Green
Multiprofessional working	All providers have teams that train and learn together	• Peer reviews not yet in place • No systems in place to learn across the	Amber

		region	
Payment System		National system not yet in test	Red

5.1 Personalised Care and Choice

Our vision for personalised care and choice is:

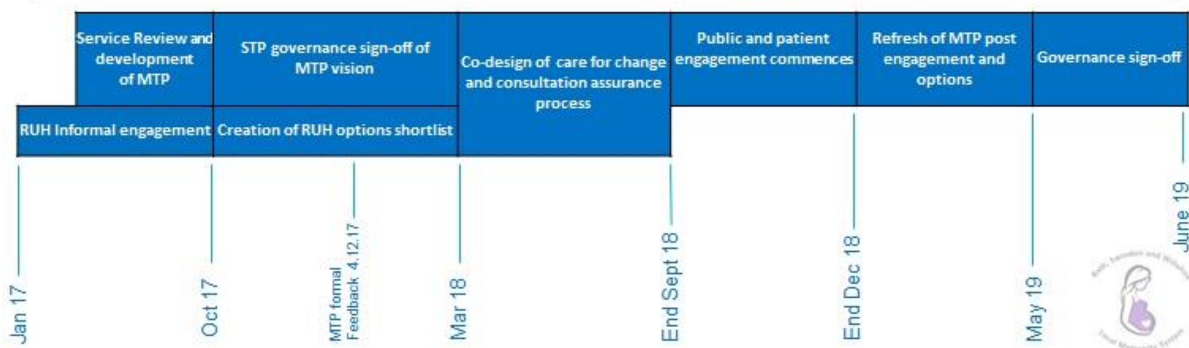
- Women and their families will be fully informed and receive unbiased information. They will be actively involved in co-creating their care plan and feel listened to throughout this process.
- Women and their families will enjoy positive experiences and feel safe.
- There is recognition that pregnancy and beyond is a dynamic pathway so as an LMS we need to be responsive and iterative and ensure there is "time to talk and time to listen".
- Staff across the LMS are confident and skilled to undertake their roles, feel supported to provide the care they want to, and have the time and capacity to provide a partnership role throughout the pregnancy journey and beyond.

All three providers currently provide individual care planning to women through historically delivered models. This process begins from the booking appointment and continues through the maternal journey to postnatal care. The LMS will be reviewing this process to ensure parity of process and patient experience across the STP footprint via the MSLC to include users and other providers across antenatal and postnatal care. The next stages are detailed in the action plan on page 33.

A dedicated Programme Board utilising a full PMO (project management) approach has been developed to support the choice of place of birth work stream. Informal staff and public engagement began in January 2017 and a shortlist of options for redesign will be agreed by March 2018. This may require formal public and staff consultation depending on the agreed shortlist. This redesign work will cover provision of antenatal, postnatal and labour care as well as consideration of the number and location of maternity clinical hubs and will reflect the priorities set out in Better Births. The following table demonstrates the proposed timeline for this work, which has been mapped across the revised NHS service reconfiguration model. We are currently working on stage one of this process. We are currently working on stage one of this process with an expected Stage 1 NHS reconfiguration meeting timetabled for April 2018. As a result of the mandated revised service reconfiguration requirements, our initial project plan timetable has been revised.

Next Steps + Programme Delivery

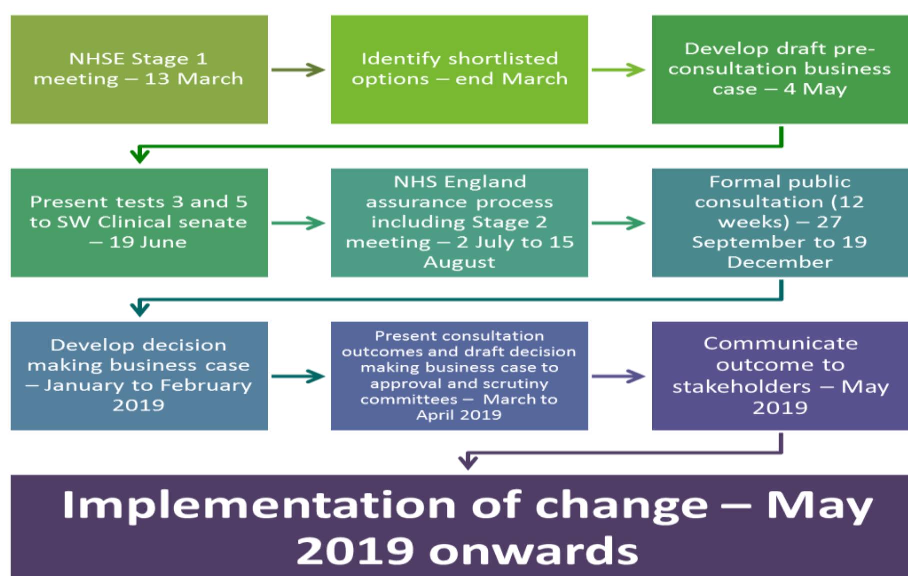
Action	Date	Status
1. Co-creation of strategic Maternity Transformation Plan (MTP) **stage one**	July - September 2017	Complete
2. Draft MTP submitted – **stage one**	October 20th 2017	Complete
3. RUH informal engagement commenced – **stage one**	January 2017	Complete
4. RUH informal engagement long list of options scored – **stage one**	September – November 2017	Complete
5. Identification of short list options to inform LMS plan – **stage two**	December 2017	Complete
6. Co-design of LMS proposal (Including RUH elements) – **stage two**	January – July 2018	In Progress
7. Discussion, Assurance and Approvals for recommendations for change (inc. NHSE, Clinical Senate, HOSC, Boards etc.) – **stage three/four**	July - September 2018	
8. Development of consultation plan and materials – **stage three/four**	May-September 2018	In Progress
9. Formal public and patient engagement and / or consultation – **stage five**	End of September - end of December 2018	



5.1.2 Service Reconfiguration

A key element of this work stream is a maternity service reconfiguration review. Informal staff and public engagement began in January 2017 and a shortlist of co-created options for redesign has been agreed. Formal public consultation, in line with the revised NHSE service reconfiguration model, will be commencing in September 2018.

This redesign work will cover provision of antenatal, postnatal and labour care and will reflect the priorities set out in the National Maternity Transformation Programme. The following diagram demonstrates the timeline for this work:



A dedicated Maternity Services Steering Group utilising a full PMO (project management) approach has been developed to support the service redesign work stream. The Clinical Case for Change has been drafted for full STP footprint governance sign off and includes nationally led improvement work such as Better Births, the wider Maternity Transformation Programme and local drivers highlighted in this plan. A Clinical Senate Review will take place in June 2018 as part of the assurance process.

The rationale for this redesign work is that the current choice of place of birth for women and families is resulting in:

- Underutilisation in some care settings
- Mismatch between workloads and staffing levels
- Current variation in LMS provision and birth environments

The key aims of this programme are:

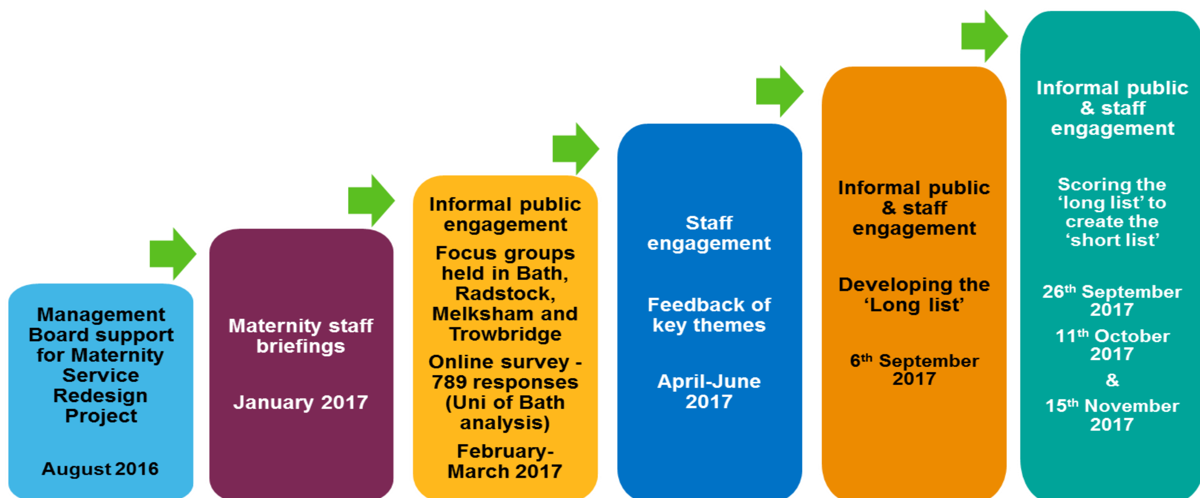
- Improved outcomes and experience across STP
- Safe and consist service
- Parity of access
- Maximising efficient use of resources

The sign-off process for any change proposals will include the BSW STP, HOSCs, CCG Governing Bodies, and Acute Provider Boards and will follow the defined NSHE Service reconfiguration process. Communication with all these partners has already commenced at pace with informal briefings provided to all partners by May 3rd 2018. Communications and engagement activities will be overseen by the LHE Communication and Engagement Working Group, reporting into the Acute Maternity Services Steering Group.

The LMS recognises that there is the opportunity to further improve maternity services, to focus on safety and equity, and to be responsive to the choices that women are making. Before developing any options for service change, there has been a period of informal engagement to help understand what matters most to our maternity service users, what families want from our maternity services and what drives the choices they are making in relation to their care and decision making around where to have their baby. Informal engagement also sought to understand what service users feel is good about current service provision and what they would like to see improved.

To gather this information, in January 2017 the RUH launched informal patient and public engagement activity to broadly outline the need for change and to gather feedback on what matters most to women and families when choosing where to give birth. Over the period of 3 months they had feedback from over 800 people including staff, mums and stakeholders, via questionnaires and discussion groups. A summary of engagement activities is set out in the diagram below.

Summary of engagement activities

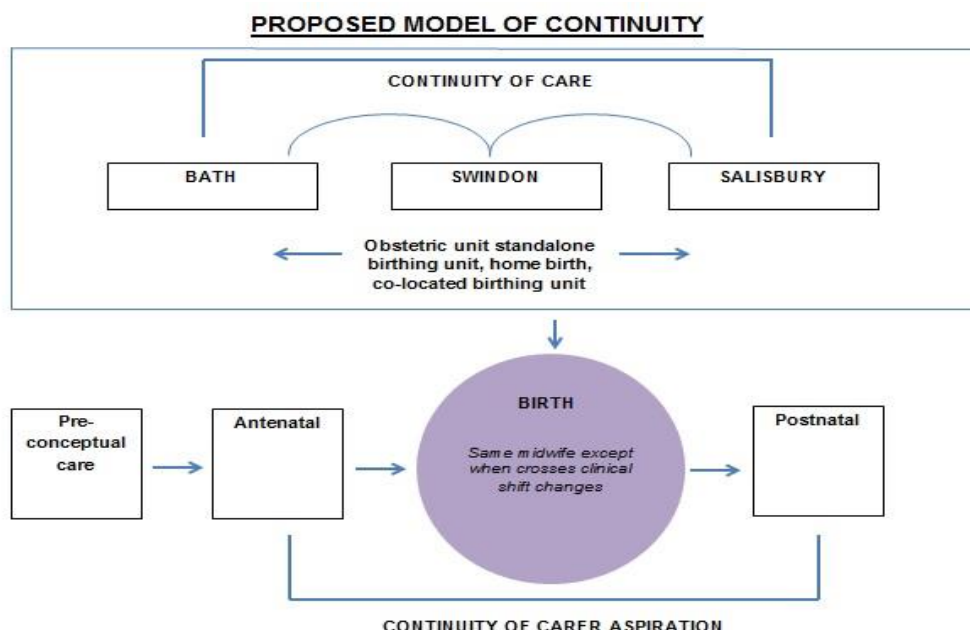


Outputs from this informal engagement work have been used to support the development of a long list of options which has been scored against defined criteria to create a short list of options. In parallel the MSLC undertook a place of birth survey to understand the views of women and families. In two weeks, over 850 responses were received and this rich data has also been used to inform our case for change.

5.2 Continuity of Carer

The LMS is exploring a pilot approach to delivering the continuity of carer agenda. The diagram below details the potential options of delivering continuity of care for antenatal and postnatal pathways across the STP footprint.

Figure 7: Proposed Model of Continuity



Our vision is that in the next 5 years women will be cared for by a team of professionals throughout their pregnancy, birth and postnatal journey that they know and trust.

It has been acknowledged that one of our key enablers will be workforce transformation. The LMS has agreed that we will target our initial pilots on vulnerable women and families.

Our key actions are:

1) For each provider to undertake as a QI pilot project in autumn 2018.
2) To engage the existing workforce.
3) To focus initially on providing continuity across ante-natal and post-natal pathways. On call options will be explored as part of this model to facilitate continuity of carer for the intrapartum period of care (acknowledging working time directives).
4) For obstetric teams within our providers to review continuity.
5) To undertake a full workforce review informed by the evaluation of QI pilot projects. This will link in with our planned HEE supported local workforce review.
6) To develop key messages to support expectations of women, families and staff.
7) To ensure revised models of care are supported by the appropriate protocols and infrastructure, such as agreements for staff to work across geographical and organisational boundaries.

5.3 Safer Care –

Safety of mothers and their babies is one of the most important aims in delivering maternity services. In BSW each commissioning organisation (organisations that are responsible for planning and purchasing services for their local population) has processes in place to monitor the performance and quality of the services provided to women and babies, to ensure that they deliver safe, high quality care at the appropriate time. These processes have been strengthened by collaborative commissioning agreements across the BSW LMS area. In delivering this plan, the monitoring of performance, quality and safety will be improved through the introduction of a quality and safety improvement system across the whole LMS, taking a collaborative approach to improving safety in Maternity services.

5.3.1 LMS Maternity Safety Sub-group

A clinically-led multidisciplinary LMS Maternity Safety Sub-Group has been developed; membership includes healthcare providers, commissioners, stakeholders and service users. This sub group will report directly into and will be accountable to the LMS Programme Board and ultimately to the Commissioner and Provider Boards and Networks. The first meeting of this group was held in January 2018 and is chaired by a Head of Nursing and Midwifery from within the LMS. Safety Champions for Maternity within each Acute Provider Trust participating in the national maternity and neonatal safety collaborative will also contribute to the LMS maternity safety sub-group. Quality and safety assurance is currently provided through commissioner contractual processes with each Trust. Performance of this sub group will be measured through key agreed indicators and through review of the provider dashboards.

The vision for the Maternity Safety Sub Group is for all women, babies and their families, across all care settings within the LMS, to receive the safest, highest quality care and experience with the

best possible outcome. This will be achieved through a collaborative approach with consistent and effective care.

The focus for the Maternity Safety Sub Group will be one of safe systems and processes. The group will initially focus on the development of a combined Safety Improvement Plan, supported by the Maternal and Neonatal Heath Safety Collaborative programme. **The focus will be on working to remove any barriers to implementing Better Birth recommendations with the aim of meeting the ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2025 and making**

The LMS will utilise established quality assessment frameworks, benchmarking information using data provided by the National Maternity data set and also the Southwest Clinical benchmarking dashboard. In addition national and local audits and reports will be reviewed to highlight opportunities for safety and quality improvement.

Once available the National Maternity Indicators and Quality Improvement metrics will be utilised to identify areas of concern to be reviewed and actions plans formulated.

5.3.2 Areas of Priority for LMS Safety Improvement plan.

The key areas within the safety domain to be focused on and incorporated into the LMS Safety Improvement plan are detailed in table 9.

Table 9 – Areas of priority for the LMS Safety Improvement Plan

- To review data sources to ensure all required data is available in a timely way across LMS.
- Introduction of external peer review in the event of a serious incident.
- Standardising the approach to root cause analysis
- Introduction of a human factors approach to incident investigation
- Consistency across the LMS with red flag reporting
- Consistency relating to incident reporting triggers, particularly in the event of a serious incident
- Reducing the number of still births and neonatal and maternal deaths in line with national targets – Each baby counts / Saving babies lives care bundle/NHSR
- Meeting the National Perinatal & Maternity Audit (NPMA) recommendations
- MBRRACE Saving Lives, Improving Mothers' Care lessons learned
- Transitional Care - reducing unnecessary separation of term babies (ATAIN) – NHSi Ambition to reduce admissions of full term babies to neonatal units by 20%
- Participation in the Maternity and Neonatal Health Safety Collaborative – a three year programme to improve quality and safety in maternity and neonatal units
- Health Education England funding to improve training within maternity services - multi-professional training recommendations from the 2016 National Maternity Review report: 'Better Births
- To ensure that women and their family's concerns are heard and acted upon to implement service improvements in relation to safety and quality. This would include drawing on learning from Maternity Voice Partnerships, complaints, compliments, birth reflections services and sharing with and across LMS.
- Benchmarking against national audits such as the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), the National Perinatal Epidemiology Unit (NPEU) and the National Maternal and Perinatal Audits (NMPA) – Each Baby counts and the Neonatal Critical Care review.
- Actions required to comply with Saving Babies Lives Care bundle by March 2019
- Actions required to comply with NHS resolution criteria framework.
- Integration of Maternity Safety Collaborative projects across the LMS

5.3.3 Saving Babies Lives

Saving Babies Lives is a national initiative launched in 2016 which has four key elements of care that contribute to reducing the number of stillbirths and neonatal deaths.

5.3.4 Sharing of learning

Incident investigation, complaints and claims will be shared to ensure LMS wide peer learning takes place. The group will also study thematic reviews and trends and will receive and seek feedback from local, regional and national clinical networks through joint membership. A process for sharing learning will be agreed across the LMS to include identification of key learning, process for dissemination and evaluation of effectiveness of system.

5.3.5 Healthcare Safety Investigation Branch (HSIB)

In November 2017, the Secretary of State for Health announced a new maternity safety strategy detailing plans for the Healthcare Safety Investigation Branch (HSIB) to undertake around 1,000 independent safety investigations into avoidable baby deaths and incidents of harm nationally. These investigations are expected to start in April 2018, and will focus on cases that meet the Each Baby Counts (EBC) criteria for intrapartum stillbirth, neonatal deaths and severe brain injuries, as well as all maternal deaths. The EBC is a dedicated programme, established by the Royal College of Obstetricians and Gynaecologists, to gather intelligence and information from local serious incident investigations and build a picture of national issues.

The aim is to bring a standardised approach to maternity investigations without attributing blame or liability and to ensure that families are involved throughout the investigation. The HSIB maternity implementation team are working through the finer details around approach and methodology but each investigation will:

- Identify the factors that may have contributed towards death or harm;
- Use evidence-based accounts to establish what happened and why;
- Produce concise reports in the shortest time possible

Our LMS supports this approach and will fully cooperate with any investigations that the HSIB may initiate within our LMS.

5.3.6 NHS Resolution Framework

The National Maternity Safety Strategy published in November 2017 set out the Department of Health's ambition to incentivise those who are striving to improve safety. Clinical Negligence Scheme for Trusts (CNST) is a scheme that NHS providers pay into in order for the NHS Litigation Authority to handle all clinical negligence claims that may arise. Although membership of the scheme is voluntary, all NHS Trusts in England currently belong to the scheme. It is BSW aim to submit evidence towards delivery of each of the 10 criteria in the CNST incentive scheme in order to receive a 10% reduction in CNST rate for each Trust. This has the potential to release approximately xxx which could be reinvested in safety improvement activities within maternity services. The ten safety improvement criteria that will be met are:

NHS Resolution Criteria

- 1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths.
- 2. Submission of data to the Maternity Services Data Set (MSDS) to the required standard.
- 3. To demonstrate that there are transitional care facilities that are in place and operational. to support the implementation of the ATAIN Programme.
- 4. To demonstrate an effective system of medical workforce planning.
- 5. To demonstrate an effective system of midwifery workforce planning.
- 6. To demonstrate compliance with all four elements of the Saving Babies' Lives care bundle.
- 7. To demonstrate that there is a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that we regularly act on feedback.
- 8. To evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.
- 9. To demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues.
- 10. To report 100% of qualifying incidents in 2017/18 under NHS Early Resolution scheme

CQC Assessments – Maternity & Gynaecology Services

Below is a summary of the Maternity & Gynaecology CQC ratings for the three provider organisations within the LMS. Services are currently rated as Good overall; however, all three were rated as requires improvement in the Safety domain. This is for a variety of reasons including bereavement facilities, staffing levels, maintenance and provision of equipment.

Table 9: Maternity & Gynaecology CQC ratings

Hospital	**Safe**	**Effective**	**Caring**	**Responsive**	**Well Led**	**Overall**	Date of inspection
RUH	Requires improvement	Good	Good	Good	Good	Good	Mar-16
GWH	Requires improvement	Good	Good	Good	Good	Good	Oct-16
SFT	Requires improvement	Good	Good	Good	Good	Good	Dec-15

Each Provider has a local action plan to address recommendations from the CQC inspections and good progress has been made in a number of areas in light of the CQC Reviews. Progress against CQC recommendations will be reviewed by the LMS Programme Board on an annual basis.

6.0 Financial Case for Change

The Local Maternity System has not identified any prescribed financial savings as part of its development of this transformation plan. This has been acknowledged by the STP leadership group. However, this plan aims to deliver safe and efficient services, which reduce duplication and explore transformation opportunities. As these opportunities arise, full cost benefit analysis will be undertaken with a view to reinvesting any achieved savings in areas of service improvement to support a cost neutral approach. A potential example of this is a review of the triage process for woman in labour to standardise model of care, improve consistency and reduce duplication across the three providers.

As and when the early adopters' feedback on progress with personal budgets, the LMS will review its position and agree next steps and timeframes.

6.1 LMS Maternity Contracts

Currently the LMS has standard PBR contracts across all providers in line with the national Maternity Pathway.

6.2 Current Spend

The tables below details current spend on maternity services across the STP footprint:

Table 10a: Wiltshire CCG:

1617		1718 FOT	
RUH	£9,604,700	RUH	£10,620,455
GWH	£3,642,372	GWH	£3,696,852
SFT	£6,237,010	SFT	£7,303,294
Total	**£19,484,083**	**Total**	**£21,620,601**

Table 10b: Swindon CCG

1617		1718 FOT	
GWH	£3,878,552	GWH	£5,646,916

OUH	£25,225	OUH	£37,464
NBT	£13,792	NBT	£9,189
Total	**£3,917,569**	**Total**	**£5,693,569**

Table 10c: BANES CCG

1617		**1718 FOT**	
RUH	£6,594,755	RUH	£6,997,123
UHB	£883,242	UHB	£687,362
NBT	£123,775	NBT	£154,212
Total	**£7,601,772**	**Total**	**£7,838,697**

A Finance Working Group has been developed with its first meeting in January 2018 to commence costings of the shortlisted models of service provision. Due to the timeframes of our service reconfiguration, further data of future costings are not available at this time.

6.3 National LMS funding

The LMS has reviewed the use of its nationally allocated ring-fenced funding. The table below provides detail for the 17/18 allocation with indicative values also provided for 18/19 planning:

Table 11a: 17/18 allocation

Scheme	**Value**	**Lead**
1. Appointment of Project Midwife (band 8a 1wte) 2. Equipment for project midwife	£10,117k £2k (including mileage)	Programme Director/ Lead Midwife
3. Clinical sessions to support service reconfiguration (includes primary care)	£37.883k	Provider leads
4. Development of Maternity APP	£9k	RUH
5. Implementation of engagement with fathers – investment in Dads Pad app across STP	£14k	Public Health
6. Development of Maternity voices and public engagement	£4k	
Total	**£77K**	

Table 1b: 18/19 allocation (to be confirmed)

Scheme	Value	Lead
1. Appointment of Project Midwife (band 8a 1wte)	FYE	Programme Director/ Lead Midwife
2. Clinical sessions to support service reconfiguration (includes primary care)	0.4wte FYE	Provider leads
3. Development of Maternity APP	FYE	RUH
4. Extension of Dads Pad	FYE	Public Health
5. Development of VBAC DVD	£5k	Swindon CCG
Total	£144k	

7. Local Maternity System Vision for 2021

Our co-created LMS vision is for: ***"All women to have a safe and positive birth and maternity experience, and be prepared to approach parenting with confidence."*** Our work plan is underpinned by four core commitments:

Women and their chosen support networks will be partners in care

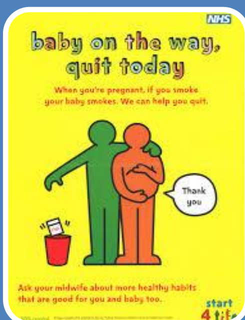
- **Women will receive unbiased, timely information to enable them to participate fully in personalised care planning, and they will be encouraged to explore and question available options. Services will reflect on the language they use, focusing on the women's experience. Above all women will be listened to.**

Maternity services and organisational partners within the LMS will work collaboratively

- **Women will receive a service that is seamless and joined up irrespective of where they access their care. Women will receive personalised care and staff will be enabled to provide continuity.**

We will enhance safety through assisting all women to experience the best birth possible for their personal circumstances.

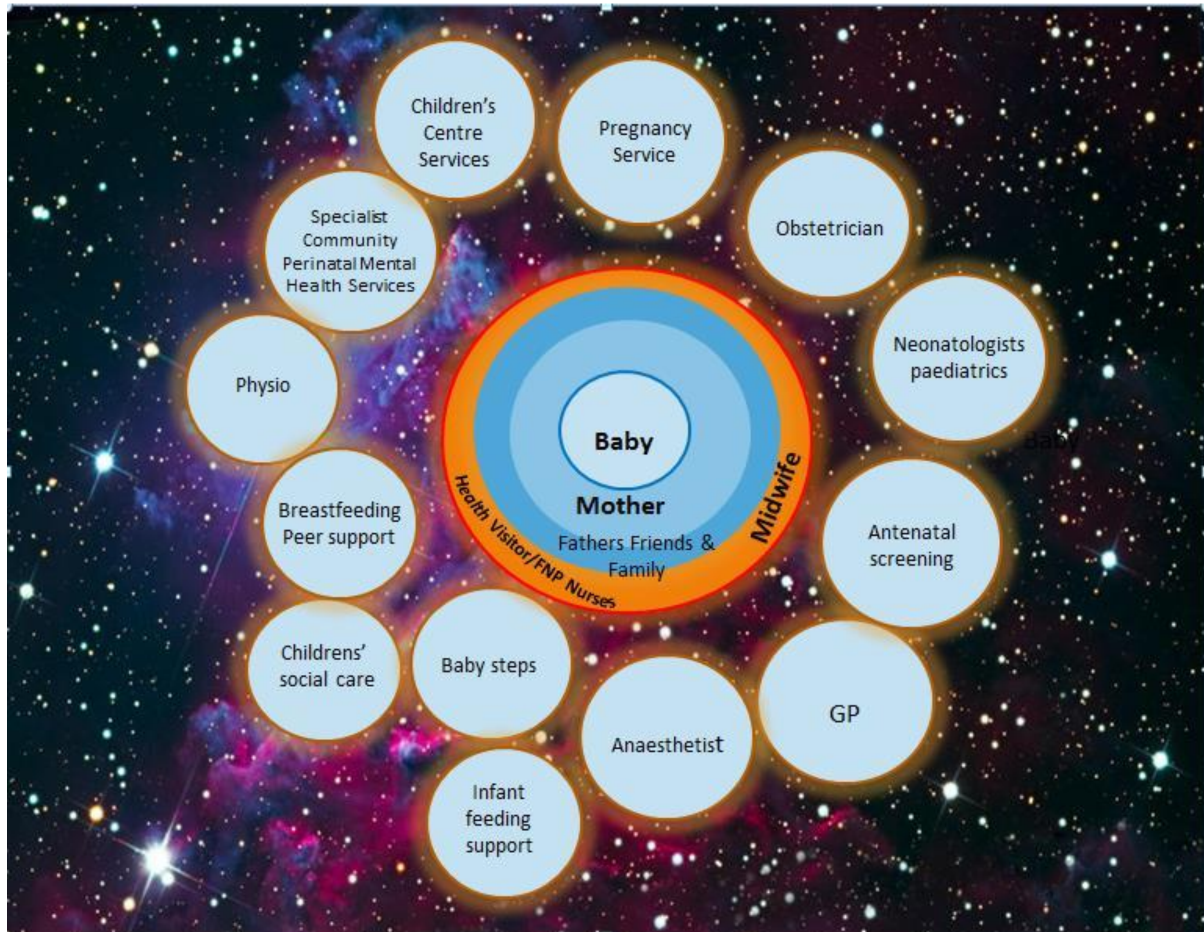
- **Woman will be supported to make informed decisions, ensuring risks and benefits are assessed, discussed and managed proportionality.**
- **We will adopt an approach that works with the physiology of labour and optimises physical and mental good health.**
- **Learning will be shared across organisations and multidisciplinary teams will learn together.**



Woman, partners and their families will be supported and enabled to optimise their health in preparation for pregnancy, birth and parenthood.

Ensuring staff have the skills and confidence to deliver consistent and effective public health interventions that positively impact on outcomes for women and children.

The diagram below illustrates the range of services that are available for woman and families during their maternity journey dependent on their level of need.



7.1 Implementing the vision

The action plan below was informed by a series of stakeholder workshops and is working document that identifies the direction of travel. This action plan will be developed further by our LMS and will be flexible to meet agreed objectives. Our focus has been on co-creation of the actions.

It is envisaged that organisations will take a lead on individual elements of the action plan. The allocation of these work streams and subsequent co-creation will take place during November 2017 and the action plan will be updated to include timescales, risks, mitigation and leads.

7.2 Trajectories and ambitions

There are a number of key national ambitions that this plan is expected to impact on. These are set out below. Where data is available local trajectories have been set to help us clearly monitor progress. Where baseline data is not yet available the LMS will prioritise identifying a baseline in the coming months so that milestones can be set.

Birth projections (detailed in section 3.3) that underpin this are summarised below.

Table 13: Birth Projections

Number of births and projection for each year				
	Local baseline	**2018/19**	**2019/20**	**2020/21**
BSW LMS	9,790	10,127	10,213	10,238
Percentage growth	-	3.4%	0.8%	0.2%

Ambitions and Trajectories				
Ambition	**Local baseline**	**Trajectory March 2019**	**Trajectory March 2020**	**Trajectory March 2021**
1. To improve the safety of maternity care so that by 2020/21 significant progress has been made towards the ambition of halving the rates of stillbirth and neonatal death, maternal death and brain injuries during birth by 50% by 2030				
Stillbirths and neonatal deaths	5.6 per 1,000 = 60 (2013-15)	55	51	48
Intrapartum brain injuries	Baseline to be set nationally			
2. To roll out personalised care planning				
Number of personalised care plans	Baseline to be set	20%	50%	60%
2. To improve choices available so that all women are able to make choices about their maternity care as envisaged in Better Births. This includes antenatal care, postnatal care and type and place of birth.				
Number of women able to choose from three places of birth	50%	60%	75%	95%
3. To improve continuity of the person taking care of women during pregnancy, birth and postnatally				
Number of women receiving continuity of carer	Baseline to be set	**20%**	**30%**	**40%**
4. To enable more women to give birth in midwifery settings (at home and in midwifery units) **Baseline 16/17 data**				
	RUH	**GWH**	**SFT**	**Total**
Number of women giving birth in all settings	**4641**	**4555**	**2202**	**11,398**

Consultant led	**3,761(80.18)**	**3635 (80%)**	**Not available**	**Not available**
Alongside midwife led	**0**	**875 (19.2%)**	**0**	**751 (6.4%)**
Free standing midwife led	**680(14.8%)**	**0**	**0**	**680**
Home birth	**137 (2.95%)**	**48 (1.05%**	**83 (3.76%)**	**249 (2.1%)**
Other	**0**	**25**	**0**	**25**
LMS Total % of Midwife led place of birth				**15%**
Total LMS % of Consultant led place of birth				**80% (2 providers)**

7.3 Shaping our LMS future and timeframes

The LMS has reviewed its detailed action plan for implementing our Maternity Transformation Plan. This features in table 14. We have also co-produced a high level summary of what will look different in 6 months, 12 months and two years. The delivery of these ambitions will be monitored by our dedicated project midwife who was appointed on January 25th 2018.

One of the key actions to be completed by the LMS Programme Board is to agree our maternity offer to women and this will be confirmed at the LMS Programme Board on July 30th 2018.

Six month ambitions

- Our Dad Pad – to support Dad's and help signpost to services – will be rolled out across the LMS and developed as an App.
- The LMS will have commenced the development of a dedicated Maternity App.
- The LMS will have commenced a Plan Do Study Act (PDSA) review of booking appointments and would have started trialling alternative models that begin the process of implementing a women led model of personalised care planning. The current data collection requirements will be reviewed to improve the experience of women and staff.
- The LMS will have developed and mobilised a 'Welcome Pack' to support women and families. This work will include a review and improvement of patient information such as greater signposting to the Which Choice tool.
- Our dedicated Safety Group will be mobilised.
- The LMs will commence exploring procurement opportunities.
- The LMS will have improved our postnatal continuity of care/r (within existing resources)
- The LMS will develop an STP approach to Perinatal and Infant Mental Health
- The LMS will have created a platform for working across boundaries – this will include IG solutions.
- The LMS would have commenced local workforce mapping linking with HEE.

12 month ambitions

- The LMS will deliver a revised choice offer for women and families.
- The dedicated Maternity App will be online and mobilised.
- The LMS will have confirmed a standardised role for Maternity Support Workers.
- The LMS will introduce group supervision to create a safe place for midwifes to discuss issues and concerns.
- The LMS will have improved capture and subsequent learning from patient experience linking in with maternity voices partnership.
- The LMS will have developed plans to improve the triage of women in labour.
- A QI and associated framework model for transformation will be implemented.
- Delivery of pilots for new continuity of carer models – focused on vulnerable women.
- The LMS will be ensuring and delivering full women and family involvement in our service reconfiguration and transformation journey.

Two year ambitions

- The LMS will be delivering improved continuity of carer to a broader cohort of women.
- The LMS will be delivering all our safety ambitions and trajectories.
- The LMS will have delivered and will be measuring the impact of a consistent parenting pathway for vulnerable groups.
- The LMS will have created and be delivering our clinical/ community hubs.
- The LMS will have created and delivered transitional care.

Key Workstreams

Cross-Cutting Themes with STP workstreams

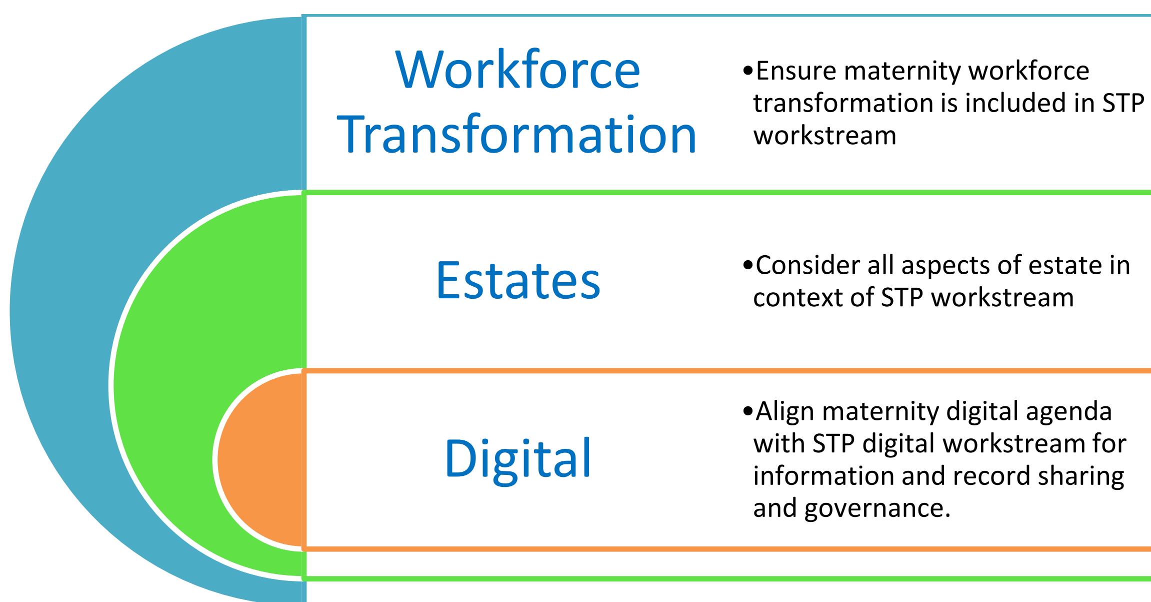


Table 14: Actions, current position and next steps

	Action	Current Position	Next Steps	Lead and timeframes
1	**Personalised care and choice**			
1.1	Share local policies and agree common language and protocols around maternity care. Align/standardise policies as much as possible.	LMS planning workshops have included discussions on common language. Non standardised language at present but each Provider already working with staff to discuss language used. Policies and protocols similar as based on national guidance but require review to identify differences that could be discussed as LMS.	• Set up LMS Policy Group • Consider drop box or other method of sharing guidelines. • Heads of Midwifery Services (HOMs) to lead standardised language work stream. • Place of birth Choice leaflet to be agreed across LMS area by Providers, LMS Programme Board and MSLC. • To reformat Maternity transformation plan into easy to read format	• Project Midwife lead August 2018 • LHE Communication and Engagement Group lead Draft by July 2018 • LMS project midwife and Communications team July 2018
1.2	Provide welcoming, consistent, unbiased, informed, timely information to women and their partners regarding their maternity care	Standardised information for women tailored to individual clinical areas available within each Trust but not in a central location for LMS.	• Project lead to procure webpage for LMS. • To consider facility for booking care and appointments online across LMS. • Draw on findings from local Place of Birth user survey to ensure women and their partners are consistently informed about the	• Project midwife to lead with support of LHE Communication and Engagement • Welcome pack to be drafted by HOM and LHE Communication and Engagement group by May 2018

			risks and benefits of all birth options in a way that is meaningful to them. • Review and where appropriate redesign provision of choice across LMS to include choice of place of birth to provide options for all women to include home, midwifery unit or in hospital obstetric unit. • Development of education programme to support choices	• Reconfiguration project team • May 2019
1.3	Align to public health strategies and be mutually supportive	Variations in public health strategies that support maternity and neonatal services.	• Redesign project group to map variation across LMS. • Baby steps evaluations to be shared across LMS. • Convene a Public Health joint working group (cross authority and providers to consider alignment of public health initiatives that impact on Maternity services across LMS area to avoid inconsistencies in care provision	• Redesign project group August 2018. • Public Health leads • Public Health Joint working Group (Cross - authority and providers) to be convened by July 2018. Lead Public Health Director

1.4	To establish Maternity voice partnerships	Established Maternity Services Liaison Committee currently in place. A variety of methods used in provider areas to obtain feedback from women and families including birth reflection services, women surveys, compliments and complaints, “graffiti boards”.	• To establish maternity voice partnerships. • To identify any resource costs for sustainability of maternity voice partnerships and construct required business case where appropriate	• Project midwife and Public Health lead • Project midwife and Lead Commissioner for Maternity.
2	**Antenatal and Postnatal care**			
2.1	Standardise antenatal and postnatal pathways for all women, ensuring timely access to the support or help needed.	Most pathways similar but require review to identify inconsistencies across LMS	• LMS and Safeguarding Specialist Midwives to agree Cross boundary policy about how vulnerable women will be identified and alerted across LMS area. • Consider central Safeguarding email address. • Review antenatal and post-natal care pathways across LMS. • Review and align protocols relating to transfer of antenatal women to optimise birth before 27 weeks at appropriate site for neonatal intensive care	• Safeguarding specialist midwives to lead linking with 6.6 June 2018 • Redesign Project Group October 2018 • By Nov 2018
2.2	Consider adopting elements of the Stepping up to Public Health (PH) resources to empower women and	No current mapping of provision of Stepping up to PH resources.	• Redesign project group to review evidence and identify pilot sites for agreed elements of Stepping	• Redesign Project group June 2018

	to enable staff to personalise maternal public health	Women do not routinely complete their own notes. Women not routinely asked to identify "what is important to you or what do you want to know about or ask".	up to PH resources. • Redesign project group to formulate proposal and present at MSLC.	• Sept 2018
2.3	Infant feeding leads and breastfeeding strategy leads to work together to contribute to Joint Strategy Needs Assessments (JSNAs) and ensure consistency of provision and messages across LMS	There are specialist infant feeding leads in all maternity and health visiting services as well as commissioning leads in each CCG. But there are differences in breast feeding policies which need to become more aligned. Although all services are Breastfeeding Friendly Initiative (BFI) accredited, women can still receive inconsistent messages from different professionals, including neonatal feeding guidance.	• Infant feeding leads currently meet quarterly and are becoming more aligned due to the SWSCN work. • Ensure governance of BFI accreditation is linked to Early Help Boards as well as contract management of services. • Work together across STP to ensure consistency in data collection and recording. • GPs and Paediatricians also need to provide consistent messages - Health visitors best placed to influence.	• Maternity and Health Visiting Services Infant Feeding Leads Sept 2018
2.4	Standardise transitional care pathways across the LMS, with a focus on keeping mothers and babies together, smooth transitions and effective communication between services at all times and	There is variation between and across maternity services in how care is provided to new babies who need additional monitoring and/or interventions.	• Acute trusts evaluating pilots. • All units to participate in the ATAIN programme to keep mothers and babies together. • Commissioners raising payment issues around transitional care at	• Provider leads (one for each Trust) November 2018

	appropriate on-going care in the community	Acute Trusts are working collaboratively towards a transitional care model Communication between maternity, Paediatrics, SCBU/NICU, GPs and health visitors, infant feeding specialists is not always consistent.	regional and national levels. • Need to develop and adopt a procedural pathway to ensure all relevant communication (including finance) and discharge summaries are completed in a timely manner.	
2.5	Adopt a consistent approach to routinely offering all women and families the opportunity to reflect on their birth experience, particularly in the early postnatal period (link to 5.4)	Each maternity provider offers the opportunity for mothers to reflect on their birth experience with a midwife and/or obstetrician. Nevertheless, the opportunity is not currently promoted/ provided routinely.	• The services will expand to offer each woman the opportunity to talk about the birth – not just those with a negative experience. Pathways to be formalised between IAPT and maternity services to ensure women are receiving the right support at the right time.	• Reflection service leads and IAPT lead Sept 2018
2.6	To ensure women and their partners are empowered and confident making the transition to parenthood and preparing for any subsequent pregnancies, actively promote preparation for parenthood and support positive parenting throughout the maternal care pathway (MSLC priority).	Delivery of antenatal education and transition to parenthood varies across the LMS (health visiting and maternity services) both in terms of content and reach. This applies to both universal provision and targeted programmes, such as Baby Steps. Access to self-funded and	• Review and collate current provision in each area including support for parents who have very premature babies. • Review learning outcomes/ take up (including fathers/ partners) and evaluate user feedback. • Continue to align midwifery and health visitor universal antenatal education offering and ensure	• MSLC to lead Sept 2018

		voluntary sector provision is also varied. IAPT group based programmes are also inconsistently provided across the area.	sessions are accessible to and meet the needs of those vulnerable families who need them most. • Raise awareness of other providers for those who can self-fund. • Consider business proposal for Baby Steps in B&NES.	
3	**Perinatal and infant mental health**			
3.1	Implement local PIMH plans and ensure synergies across LMS where appropriate (links to MSLC priority 1.3)	There are many similarities in the pathways in each area, e.g. a well-being plan is given at all bookings, but also variations e.g. the midwives screening tool questions vary. There are named MH support MWs at each acute hospital but they are not MH specialists. The adult MH provider (AWP) is the same across the STP but, there are local variations in referrals to, and provision from, Improving Access to Psychological Therapies (IAPT) and Primary Care Liaison Services (PCLS). There is a lack of specialist	• To develop an STP approach to PIMH • To develop and launch one PIMH strategy across the STP area. • An STP bid for 2018/19 'pump priming' for a new specialist community PIMH service is being prepared ready for submission to NHS England in late 2017.	• May 2018 • PIMH project manager to lead August 2018

		community perinatal MH services across the STP.		
4	**Workforce transformation**			
4.1	Ensure our workforce is designed to meet the offer of maternity care and the aims of the needs of the MTP.	Providers have carried out some workforce planning. Awaiting more details from national tools from HEE and RCM.	• Identify and work with workforce modelling experts to progress via HEE local team. • To establish a baseline for Maternity workforce across the LMS • To map workforce required against Maternity offer to identify workforce requirements using Maternity Transformation plan (HEE) when available. To ensure Workforce planning to meet demand and manage turnover and retention; ensuring sufficient flexibility, capacity and capability in the service. • To map workforce requirements for community hub model	• Provider divisional director leads and project midwife April 2018 July 2018 Oct 2018

			• Implementation of professional midwifery advocates roles (underpinning feedback/learning cycle). • Influencing cultural change to enhance flexibility and reach of the workforce in relation to health economy approach to care in ensuring a women focused ethos and culture of co-production. • Identifying and supporting Maternity Services Champions. • Identify any additional midwifery resources required to provide safe, continuity of carer models of care. • Identify backfill time required for Obstetric leads for project time.	
4.2	Ensure we have a workforce that is equipped and enabled to take forward the transformation agenda through a QI methodology e.g. PDSA	As above	• Develop HR processes to support cross boundary working • Learn from national initiatives (project midwife) • Agree QI methodology • Agree approach i.e. listening into action • Plan training and release of staff	• LMS Programme Board and AHSN support • November 2018

			• Develop clear outcome measures	
	Standardisation of Maternity Support worker role	Differences in training and job roles of Maternity Support worker across the LMS area	• To map the current training and competency standards for Maternity support workers across the Providers in the LMS. • To work collaboratively with HEI's and HEE using available information from RCM to identify an LMS agreed training, role description and competencies across the LMS. • Identify	• Project midwife (in conjunction with LMS programme board Dec 2018
5	**Continuity of carer**			
5.1	Define what continuity of carer is for our LMS	Not currently in place but each provider is mapping opportunities to provide continuity	Ambition to be designed at workshop	Lead midwife January 2018 ACTIONED
5.2	Draw on lessons learnt from early adopter sites to model continuity of carer locally	The providers within the LMS are evaluating schemes that have most relevance to their demographic	PDSA pilots to be created to explore options for continuity of carer delivery Obstetric teams to review continuity	Lead and project midwife June 2018
5.3	Link with workforce transformation work stream to develop model for achieving continuity of carer	This will be mapped, evaluated and actioned through the LMS	Full workforce workforce review following evaluation of Q1 project in each provider area with the focus on	Lead and project midwife

	through the maternity journey in response to women's local needs	Programme Board	provision of continuity of carer antenatally and postnatally initially progressing to intrapartum care following the pilot evaluation. To develop a transformational workforce model that has the potential to meet the aims of : 1.20% of women booked on a continuity of carer pathway by March 2019 2.4 40% of women booked on a continuity of carer pathway by March 2021 Review on call arrangements	August 2018 HOMS
6	**Working across boundaries / multi-agency working**			
6.1	Standardise maternity notes across LMS including personalised care plans	RUH and GWH use same notes. SFT have different notes. Aim for all areas to use the same notes.	• HOM Salisbury to discuss with Clinical Governance and agree standardised records. • To obtain and implement revised notes for Salisbury (until such time as digital records can be shared across LMS (or nationally).	• HOM SFT lead July 2018

6.2	Identify common digital platform for professionals and women, partners and families	No common digital platform- Each Maternity Service uses a different electronic records system which do not communicate. No one source of information for service users	• Project lead to co-ordinate support from national digital team • Learn from other areas that may have already progressed this action. • Undertake Digital Maternity Assessment to provide information to National digital workstream • Work to identify a digital platform to promote a wide range of positive birth stories to expectant parents and the wider community	• Project Midwife lead August 2018
6.3	Implement LMS triage system	No standard triage system at present. Background work being undertaken by midwifery representative from each Acute Trust. Expressions of interest submitted to SW Hub project.	• Working group led by Project lead to be set up by December 2018. • Share Wessex Unscheduled care pathways to use as basis for discussion of protocols. • Working group to evaluate potential use of SW Hub as LMS triage for all LMS Providers of Maternity Care with standardised triage tools.	• Project midwife to lead December 2018
6.4	Standardise birth reflections and VBAC (Vaginal Birth after Caesarean) services across the STP and feedback key themes or learning into the Safety subgroup	All areas provide Birth reflections services. No current sharing of trend analysis from Birth reflections across LMS. VBAC support services require	• Each Provider to identify VBAC /positive birth champions (Midwife and Obstetrician). • To set up quarterly meeting for champions for positive birth	• Project Midwife May 2018

	(links to 2.5)	mapping for each provider	reflections and VBAC services. • Map Positive Birth reflections services for LMS by Project lead. • Map VBAC services across LMS by project lead. • Development of educational DVD for women	• Swindon CCG Commissioning Lead July 2018
6.5	Ensure consistent public health messaging, use of online resources and signposting for information across LMS	Local currently – with variation	• Public health to be an agenda item at LMS Programme Board – link to national programme. • Consultation with service users re needs / approach. • Review BANES Early Help App – consider adopting this across LMS with local information. • Flu jabs first messages required. • Project plan campaigns with a timeline including identification of resources available / media type.	• MSLC Dec 2018
6.6	Invite appropriate early years(0-5 year) partners to discharge planning meetings and formalise MW-CC link role	Obstetricians not fully aware	• Each Trust to identify lead liaison role. • Identify Children's centre contacts. • Raise awareness of CC services across wider maternity services & locally. • Identify what meetings they are	• LMS public health lead August 2018

			required to attend - all/ selected by invitation? • To be in place by February 2018.	
6.7	Establish mechanisms to enable midwives to work across organisational boundaries	Not in place – required to aid recruitment & staffing shortfalls and spread shared practices	• Dialogue with university training schools of nursing required. Consider rotational posts. • Consult existing staff in each Trust to seek expressions of interest / suggestions on way forward. • Share learning from new LMS / SWAST Midwife role – set up (October 2017) and implementation/practice (2017/18).	• Project midwife June 2018
6.8	Develop a collective vision for community hubs across services involved in the maternal care pathway to ensure families across the STP receive a service that is as seamless	Not in place	• Share learning from Swindon Accountable Care model to be implemented 2018/19 (Team Swindon) model). • Identify what services are required in the hub to support maternity services? • Identify the expected benefits of community hub & outcome success measures?	• Lead and project midwife via LMS Programme Board June 2018
6.9	Ensure Early Help /Early Intervention strategies are linked to ensure a whole system approach across the STP.	Each CCG / Local Authority area has different arrangements for delivering the early years agenda and varying degrees of sign up	• To review strategic early years arrangements and working processes across the STP.	• LMS public health lead Sept 2018

		from agencies.		
7	**Safer Care**	**Current Position**	**Next Steps**	
7.1	Deliver against Maternal and Neonatal Health Safety Collaborative priorities.	Great Western Hospital is in Wave 2 and Salisbury and Royal United Bath are in Wave 3 of the Maternal and Neonatal Health Safety Collaborative, a three year programme to support improvement in the quality and safety of maternity and neonatal units across England.	• Each organisation will receive a wide-ranging support over the life of the programme. This includes tailored resources and networks; in the meantime learning from Wave 1 organisations will take place via clinical networks and will feed into the newly formed Maternity Safety Sub Group. • A combined Safety Improvement Plan will be developed across the LMS which will set the priorities and framework within which the Maternal Safety Sub Group will work.	• HOMs/ quality lead April 2018-
7.2	In conjunction with the South West Clinical Network develop a joint safety improvement plan across the LMS	Individual Trusts have benchmarked against Better Births and have locally agreed priorities for Maternity Safety Improvement Plan (MSIP).	• Collaborate across the LMS to develop joint MSIP. • Introduce external peer review for SI's. • Standardise approach to SI investigation using RCA and Human Factors approach. • Ensure consistency in reporting trigger framework.	• HOMs/ Quality lead May 2018- revised to June 2018

7.3	Review implementation of maternity based clinics to increase uptake of vaccination in pregnancy (MSLC priority)	Each Trust in LMS has developed its own local plan for delivering vaccination in pregnancy.	• Maternity Safety Sub Group will focus on safe systems and processes across the LMS which will include sharing ideas for implementing public health initiatives such as delivery vaccination clinics and any barriers or difficulties experienced. • Review 2016/17 data and update at maternity forum on uptake of vaccinations rates to date and agree strategies to promote including supporting across LMS. Agreed and in place for 17/18.	• HOMs ACTIONED for 17/18 MSLC discussion April 2018 to confirm plans for 18/19
7.4	Benchmarking against national audits such as MBRRACE, NPEU, NMPA and EBC and sustain implementation of recommendations such as implementation the Stillbirth Care (MSLC priority)	Each Trust within LMS has implemented the Stillbirth Care Bundle and monitors incidence of stillbirth on a monthly basis: % of women identified as smokers at booking referred to a specialist stop smoking service Proportion of women having a CO test at booking Number of unexpected SGA babies born	• Monitor and maintain through the Maternity Safety Sub Group a reduction in stillbirths and share good practice across the LMS. • Benchmark that there is consistency across the LMS of monitoring and reporting of Stillbirth interventions and outcome measures. • Prescribe, monitor and maintain safe clinical systems and processes across the LMS to ensure women who meet the	• HOMs/ Quality lead June 2018

		% of intrapartum CTG interpretations reviewed by a midwife / doctor hourly during labour No. of still births (>=24 weeks)	criteria for a more intense level of care are identified early and a personalised care plan is developed in partnership with them.	
7.5	Monitor the impact of programmes to improve health in pregnancy, share learning and identify gaps in provision (MSLC priority)	Health in Pregnancy programmes are available in some Trusts (B&NES and Wiltshire) with demographic data collected to plan services and determine efficacy. Percentage of mothers recorded as smoking at time of booking Percentage of mothers recorded as smoking at time of delivery Percentage of women with BMI 30 to 34.9 at booking Percentage of women with BMI 35 to 39.9 at booking Percentage of women with BMI 40 to 49.9 at booking Percentage of women with BMI 50+ at booking	• Need to identify current position, some Trusts are able to offer focused health improvement programmes as a result of commissioning priorities. • Identify targeted interventions and any training required for professionals to optimise discussions with mothers regarding smoking using motivational interviewing techniques • Monitor compliance with Saving Babies Lives element in each provider Trust to increase smoke free pregnancies.	• HOMs/ Quality lead/ Lead LMS public health Via LMS programme Board June 2018 • Public Health leads, practice development midwives • LMS Safety subgroup

7.6	Improve understanding of the definition and prevalence of vulnerabilities in pregnancy across the STP and work to improve engagement and support for vulnerable women and their families (MSLC priority) links to 5.8	Baseline data is currently being collected across the LMS for the period 2016/17 and Q1 2017/18 which includes: Vulnerabilities: <20 years / substance misuse / perinatal mental health / homeless or housing issues / domestic abuse / recent arrival as a migrant / asylum seeker or refugee / English as a second language / concealed pregnancy Method: % of pregnant women with one of the vulnerability factors listed above (total of all pregnant women as denominator) at booking % of pregnant women with 3 or more of the above vulnerability factors at booking % of pregnant women at booking	• Review the data to establish the current picture across the LMS and develop strategy in response. • Ensure consistent application of vulnerability criteria across maternity, health visitor and Children's Centre services which is consistent with the LSCB thresholds. • Review and update maternity and health visitor liaison pathway as part of LMS work.	• Public health lead and HOMs June 2018 • Sept 2018

		with the ‘toxic trio’ at booking		
7.7	Ensure commissioners and maternity services are responding to demographic changes among women of childbearing age and considering the needs of particular vulnerable groups, including Syrian refugees, European migrants and military families (MSLC priority)	Not yet started	• Work with commissioners and provider business analysts to agree the data set to be collected across the LMS to enable personalised care is planned in response to demographic needs.	• LMS Programme Board April 2018
7.8	Ensure effective supervisory mechanisms are in place to support midwives locally (MSLC priority)	Each individual Trust has developed a plan to support implementation of the AEQUIP Professional Midwifery Advocate role.	• To scope whether there is a need to provide cross boundary cover across the LMS.	• Lead and project midwife May 2018
7.9	Clinicians from each provider to actively participate in the Strategic Clinical Network to drive continuous improvement	Membership already established	Joint membership will be in place across the LMS within clinical networks and Maternity Safety Sub Group.	• HOMS and quality lead Ongoing
7.10	Work closely with neonatal network to align strategies	Already established	Joint membership will be in place across the LMS within clinical networks and Maternity Safety Sub Group.	• HOMS and quality lead Ongoing

7.4 Co-production of the Plan

A Maternity Transformation Plan (MTP) planning event was held in June 2017 for service users, leads and staff from maternity and early years' services to reflect on the Better Births report and identify key areas for action locally. A small task and finish group came together afterwards to pull together the ideas generated on the day and formulate a draft plan. A subsequent event was organised in September 2017 to present the draft MTP to those who attended the June event to obtain feedback. The opportunity was also taken to begin work on an area for action identified in June, namely to change some of the language used during pregnancy and birth to become more user friendly and create more positive perinatal experiences for women and their partners. A further workshop was held in January 2018 to co-produce and finalise our mobilisation action plan, which features in table 14.

7.5 MTP Co-ordination and implementation

Our LMS is developing a proposal to use assigned national ring-fenced funds to appoint a dedicated Project lead midwife and obstetrician time to help deliver the actions assure progress and support clinical engagement and ownership.

It is envisaged that each provider will identify leads for the key themes of the plan within their teams who will liaise with each other and with the MTP Project Lead to ensure actions are implemented effectively and equitably across the LMS where appropriate.

A detailed communication and engagement strategy will be developed as part of this plan. This will build on the RUH Maternity redesign programme, which commenced in January 2017 prior to the conception of the Local Maternity System. The communication and engagement strategy will be co-designed with providers and stakeholders by mid-June 2018.

8 The role of service users and opportunities to provide feedback

There are a range of opportunities for women accessing maternity care and those supporting them to feedback on their experience including social media, real-time feedback, 'Friends and Family', and provider surveys.

Service users have been centrally involved in the local MSLC for several years, providing the user perspective at meetings and taking forward discreet pieces of work, such as a birth environment audit and more recently, developing a place of birth user survey to which over 800 service users responded.

It is recognised there is more to be done to improve how services engage with women accessing maternity care and those supporting them and how we as an LMS listen and respond appropriately. Ideas for improvement include:

- collating service user feedback that providers and user representatives are gathering across the LMS in a way that can inform service improvement
- pro-actively seeking feedback from a representative sample of service users, not just relying on those who are confident at voicing their experiences

- ensuring we are engaging with the wider community, especially partners and families including those from harder to reach groups within our demographic

Plans are in place to work with current MSLC user representatives and others expressing an interest to be involved in maternity service improvement to take forward this work. The development of a Maternity Voices Partnership is being discussed to build on the good work to date engaging service users.

Each provider and commissioner has a documented and advertised complaints process to support woman, families and carers when things go wrong.

9 Risks

Table 15 details current identified risks. This will be expanded and the level of risk scored by the MOS by the end of Nov 2017.

Table 15: Risks

Focus	Risk	Mitigations
Workforce	Due to the staffing models recommended by Better Births, there is a risk that they cannot be fully implemented without additional investment.	Involvement of national team to develop models of care that is deliverable and sustainable.
	Due to the shortage of skilled midwives, there is a risk that insufficient staff can be recruited / retained to implement the new models of care.	Link with HEE work, STP workforce plan etc. Share successful strategies
	Due to proposed significant changes to working practices, there is a risk that staff availability will decline.	Ensure staff involvement and engagement with Better Births recommendations.
LMS and Accountable Care organisational development	Due to the large number of agencies involved, there is a risk that agreeing shared goals and objectives will be difficult and time consuming	Regular maternity forum and MSLC meetings with attendance by appropriate decision makers.
	Due to operational /financial issues with identifying host or new buildings, there is a risk that Community Hubs cannot be established	Primary focus is on shared care approach during transition period to National transformation of Health and Social Care.
Service Performance	Due to the proposed changes to established models of care, there is a risk of unintended consequences resulting in deteriorating performance.	Use of robust Quality Improvement methodology to inform change strategies. Continuous monitoring of outcomes with benchmarking against SW and national key performance indicators.
Service Users	Due to national developments there is a risk that women will request personal budgets for their maternity care and a decision has been made by the LMS to defer this offer.	The Maternity Transformation Plan will clearly set out what women and their families can expect.

Finance	Due to resources allocated full implementation of Saving Babies Lives criteria at GWH may not be achieved.	Business plan for resources required to achieve full compliance.
Service reconfiguration	Risk of delay due to assurance process requirement of reconfiguration	Risk
	Risk of damage to organisational reputation if adverse media interest or judicial review	Follow reconfiguration process fully. NHSE assurance support. Clinical Senate review Regular updates for Local Governing , Providers and STP Boards

10 Conclusion

This document sets out the initial strategy as co-created by the LMS and wider stakeholders. It is envisaged that it will inform the basis of improvements to our services for our women, babies and families. It is recognised that it will evolve in line with national maternity transformation developments.

References

South West Clinical Network Maternity Dashboard: http://maternitydashboard.swscn.org.uk/

PHE Public Health Pregnancy and Birth profile: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy

Universal health visiting service: mandation review:

https://www.gov.uk/government/publications/universal-health-visiting-service-mandation-review

Wiltshire, Swindon and Bath and North East Somerset Stillbirth and Infant Mortality Report (2017)

Appendix 1: Current membership of the core LMS (Maternity Forum and MSLC)

Acting Director of Acute Commissioning (Programme Director for Maternity STP)	Wiltshire CCG
STP/ LMS lead midwife	SFT
STP / LMS lead public health representative	Wiltshire Council
Project Midwife	LMS
Lead Consultant	RUH/SFT
Lead GP	Banes CCG
Quality lead	Wiltshire CCG
Finance lead	Wiltshire CCG
Comms and engagement lead	RUH/ WCCG
Project manager (service reconfiguration)	RUH
Associate Director for Quality	Wiltshire CCG
Commissioning lead	B&NES CCG
Commissioning lead	Swindon CCG
Consultant Obstetrician and Gynaecologist	Royal United Hospitals Bath NHS Foundation Trust,
Community and Acute Matrons	Royal United Hospitals Bath NHS Foundation Trust,
Head of Nursing and Midwifery, Women & Children's Division	Royal United Hospitals Bath NHS Foundation Trust,
Women and Children's Divisional Manager	Royal United Hospitals Bath NHS Foundation Trust,
Acute and Community Midwifery representation	Royal United Hospitals Bath NHS Foundation Trust,
Infant Feeding Specialist	Royal United Hospitals Bath NHS Foundation Trust,
Senior Midwifery Matron	Royal United Hospitals Bath NHS Foundation Trust,
Consultant Obstetrician	Great Western Hospitals NHS Foundation Trust
Community Midwife	Great Western Hospitals NHS Foundation Trust
DAU Midwife (lead for Diabetes in DAU)	Great Western Hospitals NHS Foundation Trust
Consultant Obstetrician and Gynaecologist	Great Western Hospitals NHS Foundation Trust
Clinical Midwifery Manager	Great Western Hospitals NHS Foundation Trust
Maternity Support Worker	Great Western Hospitals NHS Foundation Trust
Consultant Paediatrician (special interest in SCBU)	Great Western Hospitals NHS Foundation Trust
Head of Midwifery	Great Western Hospitals NHS Foundation Trust
Head of Maternity and Neonatal Services	Salisbury NHS Foundation Trust
Consultant obstetrician and gynaecologist (Head of Obstetrics and Gynaecology Service.	Salisbury NHS Foundation Trust
Labour Ward Manager	Salisbury NHS Foundation Trust
Community Midwifery Manager	Salisbury NHS Foundation Trust
Safeguarding Midwife	Salisbury NHS Foundation Trust
Antenatal Services Manager	Salisbury NHS Foundation Trust

Infant Feeding Lead	Salisbury NHS Foundation Trust
Midwife	Salisbury NHS Foundation Trust
Midwife	Chippenham Birthing Centre
Head of Service, Health Visiting	Bath and North East Somerset Community Health & Care Services
Family Nursing Partnership	Bath and North East Somerset Community Health & Care Services
Infant Feeding Lead	Bath and North East Somerset Community Health & Care Services
GP	Wiltshire CCG
Quality Manager	Wiltshire CCG
Quality Manager	Swindon CCG
Principal Officer – Health & Wellbeing	Swindon Council
Public Health Commissioning & Development Manager, Children and Young People	B&NES Council
CAMHS and Maternity Commissioning Project Manager	B&NES CCG
Lead Commissioner	Wiltshire Council
Acting Director of Public Health	Wiltshire Council
Assistant Director for Children and Young People's Service	Wiltshire Council
Head of Service (Conception to 5 years)	Wiltshire Council
Screening & Immunisation Coordinator	NHS England
Patient Safety Programme Director	West of England Academic Health Science Network
South West Maternity and Children's Clinical Network Manager	NHS England
Quality improvement Lead, South West Clinical Network	NHS England
NCT Antenatal Teacher and NCT Doula	NCT
Service User Representatives	
Health watch representative	
Children Centre Representatives	B&NES, Swindon and Wiltshire Children Centre's Services
Health Visiting Team Leaders	B&NES, Swindon and Wiltshire Health Visiting Services

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Virgin

Maternity Strategy
& Liaison Committee
Wiltshire • Swindon • Bath & North East Somerset

NHS
Wiltshire
Clinical Commissioning Group

NHS
Bath and
North East Somerset
Clinical Commissioning Group

NHS
Swindon
Clinical Commissioning Group

NHS
Royal United Hospitals Bath
NHS Foundation Trust

NHS
Great Western Hospitals
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

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Somerset Council