Implementing *Better Births*

A resource pack for Local Maternity Systems

Five Year Forward View

March 2017

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The commissioning guidance for maternity care contains advice and guidance to support clinicians, clinical leads, CCG and NHS England commissioning managers, Clinical Networks, Sustainability and Transformation Plan (STP) leads and Local Digital Road Map leads on the practical considerations in implementing *Better Births*. The content of this document is based on the learning accumulated from the National Maternity Review, leading to the creation of *Better Births*, the work of the *Better Births* national work streams and innovative practice being developed at a Clinical Network, STP or CCG level.

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Foreword

Better Births set out a compelling view of what maternity services should look like in the future. The vision is clear: we should work together across organisational boundaries in larger place-based systems to provide a service that is kind, professional and safe, offering women informed choice and a better experience by personalising their care.

Whilst *Better Births* described the vision, this resource pack sets out in detail what needs to be done and how it can be accomplished across the whole of England. It is designed to provide tools to help Local Maternity Systems turn the vision into reality and the practical advice needed to plan, commission and operate maternity services in their localities.

Better Births' vision is transformational. As with most things that are worth doing, this transformation will not be achieved without hard work, innovation and, in some cases, upheaval. We will need to think differently about the way we do things. Achieving the vision is as much about changing cultures and creating a lasting ethos of greater collaboration as it is about system design. This will require change in many places and organisations, and also in us as individuals. The potential rewards in terms of outcomes and experience for women and their families make this effort worthwhile and will lead to maternity services that we can all be proud of.

This resource helps to provide the impetus for Local Maternity Systems to start that transformational journey.

We would like to thank all the service users, obstetricians, midwives and other clinicians, along with commissioners and other system leaders who have helped us with this resource pack.

Your continuing support for the Maternity Transformation Programme helps to ensure that everything we do is focused on empowering and enabling local leaders to bring about the change required.

Sarah-Jane Marsh, Chair of the Maternity Transformation Board

Professor Jacqueline Dunkley-Bent OBE, Head of Maternity, Children and Young people, and National Maternity Safety Champion.

Dr Matthew Jolly, National Clinical Director for Maternity and Women's Health, and National Maternity Safety Champion.

Executive Summary

In February 2016 *Better Births* set out the *Five Year Forward View* for NHS maternity services in England. *Better Births* recognised that delivering such a vision could only be delivered through locally led transformation, suitably supported at national and regional levels. This resource pack is designed to help Local Maternity Systems to lead and manage that local transformation.

The pack provides advice on how to implement the key deliverables for Local Maternity Systems and enablers which may be required to support the deliverables. For each it:

- Recaps what *Better Births* says about the issue.
- Explains what the national programme is doing to provide support.
- Summarises what Local Maternity Systems might need to do and gives some pointers for how they might go about it.

The key **deliverables for Local Maternity Systems** are:

- To establish their Local Maternity System to design and deliver maternity services across boundaries, often commissioning across boundaries:
  - By March 2017 create a Local Maternity System coterminous with the STP Footprint and involving all commissioners and providers of maternity services, as well as service user fora (e.g. MSLCs).
  - By October 2017 establish a shared vision and plan to implement *Better Births* by the end of 2020/21.
- Plans to implement the vision in *Better Births* will need to include delivery of the following by end 2020/21:
  - Improving choice and personalisation of maternity services so that:
    - All pregnant women have a personalised care plan.
    - All women are able to make choices about their maternity care, during pregnancy, birth and postnatally.
    - Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.
    - More women are able to give birth in midwifery settings (at home and in midwifery units)[1].
  - Improving the safety of maternity care so that by 2020/21 all services:
    - Have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030.
    - Are investigating and learning from incidents, and are sharing this learning through their Local Maternity Systems and with others.
    - Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme.

Plans will need to consider the financial case for change, including overall affordability, transition and recurrent costs, assumptions about savings and how the transformation will contribute to the Sustainability and Transformation Plan's financial balance.

This resource pack also sets out detail on several enablers which will support the delivery of Local Maternity Systems' vision:

- Effective **service user co-production.** We recommend establishment of independent formal multidisciplinary committees, which we call "Maternity Voices Partnerships" (formerly MSLCs), to influence and share in local decision-making.
- Collecting the right **data and information**, and using it to improve services. This means participating in and making use of nationally developed data collections and tools, and implementing a strategy to use this information to improve services. It includes learning from incidences of harm.

1 Evidence will be gathered from Early Adopters and other leading systems to consider whether more specific national ambitions should be put in place for the continuity of carer and midwifery birth measures during 2017. Local Maternity Systems are asked to begin to define and plan to meet local ambitions in these areas.

- Moving from a traditional service- specific approach to **outcome-focused commissioning**. This means identifying the outcomes which require improvement, developing key performance indicators and building these into contracts to incentivise collective action across boundaries, often commissioning across boundaries.
- Focussing services in the community, using the **Community Hub** model where appropriate. This means bringing services together based on the needs of the local community, infrastructure available and pathways commissioned.
- Nurturing a **culture** which puts women at the centre of care, supports multi-professionalism and values learning.
- Developing a strategy for supporting and developing the **workforce**. This means agreeing models for the future staffing of local services, leveraging a local workforce supply to meet local needs, working with Local Workforce Action Boards.
- Identifying **digital opportunities** and ensuring key developments are part of your Local Digital Roadmap.
- Considering the role the **payment** system can play in supporting local transformation, enabling service delivery across traditional boundaries.

This resource pack also sets out guidance on how Local Maternity Systems might embed and improve the prevention, mental health and postnatal care aspects of their pathways, and how they can ensure effective integration with neonatal care.

It does not have all the answers. Seven Early Adopter Local Maternity Systems are forging ahead to develop and implement elements of local transformation. Seven Maternity Choice and Personalisation Pioneers are also testing out ways to improve the choices women can make about their care. The learning and solutions from these areas will be shared to help other Local Maternity Systems."

Please contact **england.maternitytransformation@nhs.net** or your local maternity Clinical Network with questions, comments or suggestions.

Contents

1 Introduction

1.1 National vision, local transformation

In February 2016 *Better Births* set out the *Five Year Forward View* for NHS maternity services in England:

Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning and break down organisational and professional boundaries.

A national Maternity Transformation Programme has been established to take forward implementation of the vision. However, *Better Births* recognised that delivering such a vision would rely primarily on local leadership and action. Consequently, it recommended commissioners, providers and service users coming together as Local Maternity Systems to deliver local transformation.

This resource pack is designed to help **Local Maternity Systems** provide the leadership and deliver the action to make that local transformation happen.

It is also designed to help Local Maternity Systems deliver the Secretary of State for Health's ambition for the NHS to halve the number of stillbirths, neonatal deaths, maternal deaths and serious brain injuries occurring during birth. Delivering this ambition is a fundamental aim of the Maternity Transformation Programme.

Further sources of information

→ *Better Births*: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care

→ Ambition to halve rate of stillbirths and infant deaths

1.2 How to use this resource pack

The pack covers a range of themes spanning the maternity and neonatal pathway, and the systems and enablers which underpin it. For each, it:

- Recaps what *Better Births* says about the issue.
- Summarises what the national programme is doing.
- Explains what Local Maternity Systems need to do and provides examples and practical support to help them.

It contains links to further sources of information and tools. It does not necessarily need to be read through in one sitting; rather it is for local leaders to keep as a reference and dip in and out as needed.

1.3 Support for local transformation

Local Maternity Systems will be able to access coordinated support from NHS England and other system partners. A bespoke support package will be devised in partnership with Local Maternity Systems themselves, and provided through the maternity Clinical Networks, regional maternity boards and the national programme team working together. It will be tailored to the needs of each Local Maternity System, taking into account local opportunities, circumstances and challenges.

The roles of the different teams are:

- Maternity Clinical Networks will work in close partnership with Local Maternity Systems and be their primary source of support. Clinical Networks will provide clinical input and expertise, supporting Local Maternity Systems to establish themselves, and draw up and implement local maternity transformation plans. They will help Local Maternity Systems understand and interpret national policy for local implementation. They will support benchmarking of the quality of services and spread good practice from across the country. They will bring in different parts of the system as appropriate to support individual Local Maternity Systems resolve particular local issues and challenges.
- Complementary Neonatal Operational Delivery Networks will also be able to help Local Maternity Systems deliver ensure services are seamless, providing high quality care to mother and baby
- Regional boards are responsible for overseeing and supporting delivery locally by Local Maternity Systems. They will have responsibility for assurance of both the development and the implementation of Local Maternity Systems' transformation plans, and for coordinating the support offer to each. There will be a lead nominated in each region to chair the board and resources provided to support its operation.
- The national Maternity Transformation Board is responsible for coordinating action nationally in line with the vision set out in *Better Births*, supported by the national programme team. Its role is to work through the regional boards in supporting and assuring delivery; and doing those things which require action once. The national programme team will attend regional boards, providing evidence and learning from other regions where needed.

At the same time, seven Early Adopter Local Maternity Systems are forging ahead to develop and implement elements of local transformation. Seven Maternity Choice and Personalisation Pioneers are also testing out ways to improve the choices women can make about their care. The learning and solutions from these areas will be shared to help other Local Maternity Systems.

1.4 Next steps

This resource pack will continue to develop and evolve as additional best practice, exemplars and solutions are generated by Local Maternity Systems and additional support tools are brought on-line. We have signalled throughout the pack where we know further updates will be required and, wherever possible, when.

Seven Early Adopters have committed to pave the way for national roll out of initiatives, including:

- Implementing at scale and pace all of the recommendations in Better Births.
- Delivering improved outcomes and experience of care, and reducing inequalities.
- Sharing learning and experience across wider geography.
- Evaluation at individual and programme level.
- Ensuring robust local leadership, governance and adequate resources.
- Three Early Adopters (Birmingham and Solihull United Maternity and Neonatal Partnership (BUMP), Cheshire and Merseyside and North Central London) have broad plans to implement the Better Births vision.
- Dorset Early Adopter is focusing on single point of access, fast track care planning and postnatal care.
- North West London Early Adopter is focusing on continuity of care, single point of access and postnatal care.
- Somerset Early Adopter is focusing on continuity of carer, electronic patient records, and postnatal care.
- Surrey Heartlands Early Adopter is focusing on continuity of carer, single point of access, electronic patient records, postnatal care and care planning.

2 Local Maternity Systems

2.1 What does *Better Births* say?

On a more local level, providers and commissioners should operate as local maternity systems, with the aim of ensuring that women, babies and families are able to access the services they need and choose, in the community, as close to home as possible.

Local maternity systems should be responsible for:

- *developing a local vision for improved maternity services and outcomes based on the principles contained within this report; which ensure that there is access to services for women and their babies, regardless of where they live.*
- *helping to develop the maternity elements of the local sustainability and transformation plans being developed in each area of England.*
- *including all providers involved in the delivery of maternity and neonatal care, as well as relevant senior clinicians, commissioners, operational managers, and primary care.*
- *ensuring that they co-design services with service users and local communities.*
- *putting in place the infrastructure that is needed to support services to work together effectively, including interfacing with other services that have a role to play in supporting woman and families before, during and after birth.*

2.2 What is the national programme doing?

The national programme will make available a bespoke support offer for each Local Maternity System. This will cover:

- Support to develop local leadership capacity and capability.
- Clinical and technical advice to develop tailored local solutions to improve maternity services.
- Access to national policy officials to work through the local implications of national policy constraints.
- Access to transformation funding through a best value framework.

The national programme will also seek assurance of Local Maternity Systems (through regional boards). Details of the key lines of enquiry that will be used by regional boards are set out in Annex A.

2.3 What do Local Maternity Systems need to do and how?

The purpose of a Local Maternity System is to provide place-based planning and leadership for transformation. Its first task is to put in place the governance, structure and membership required to discharge this purpose effectively. Subsequently, it has two objectives to fulfil:

a. To develop and implement a local plan to transform services as part of the local STP.

b. To establish and operate shared clinical and operational governance, to enable cross-organisational working and ensure that women and their babies can access seamlessly the right care, in the right place, at the right time.

2.3.1 Establishment

What?
By 31 March 2017 local commissioners and providers should work collaboratively to establish a Local Maternity System that is coterminous with the footprint of the Sustainability and Transformation Plan.

How?
The Local Maternity System will need to bring together representatives from a wide range of organisations. The exact membership will be for local areas to determine, but they will want to consider the table below.

Potential membership of a Local Maternity System	
Service user voice	Maternity Voices Partnerships, Healthwatch and representative parent groups where appropriate Local stakeholders and charities representing service users
Commissioners	CCGs NHS England Local Authority directors of public health Other Local Authority as appropriate
Providers	Providers of NHS antenatal, intrapartum and postnatal care including independent midwifery practices and voluntary and community sector providers involved in providing the local NHS-funded maternity offer Local Neonatal Operational Delivery Network Primary care Ambulance and NHS 111 services Mental health teams, including mother and baby units, IAPT, AMHS, CAMHS Community child health and tertiary centres. Local authority providers of health visitor services, children and adult social care teams and public health programmes.
Others	Representatives of other clinical networks, higher education establishments and teaching hospitals involved in workforce training and research Local workforce advisory boards Representatives of the staff voice, such as professional organisations and trade unions

At the same time, Local Maternity Systems will want to ensure they have adequate clinical, as well as managerial engagement. A means of enabling co-production with service users is an essential element and further guidance on this can be found in chapter 4. Local areas will also want to ensure that there is close co-operation with existing Neonatal Operational Delivery Networks and their associated Neonatal Clinical Oversight Groups, Perinatal Mental Health Networks and Urgent and Emergency Care Networks, on whose services the Local Maternity System will depend. However, it may be proportionate to involve some individuals when relevant issues are being discussed, rather than as standing members.

The Local Maternity System will require a strategic partnership board to make decisions. It will need terms of reference setting out the following:

- Purpose and objectives of the Local Maternity System board (reflecting both this resource pack and local priorities).
- Formal accountability and other lines of reporting.
- Membership.
- Rules for appointing the chair.
- Decision-making processes, including any requirements to secure agreement for key decisions from member organisations.
- Practical matters: frequency of meetings, quorum and deputies.

The Local Maternity System is essentially the maternity element of the local Sustainability and Transformation Plan (STP), with which it needs to be aligned. Accordingly, it should be overseen by the STP's strategic partnership board and it is recommended that the Local Maternity System acts as a formal sub-group of the STP. It will need to work alongside STP enablers, such as the Local Digital Roadmap.

The Local Maternity System will also need effective leadership. This means establishing a named senior leader who is connected into the governance of the STP.

Local Maternity Systems are not statutory bodies in their own right. Therefore, the legal accountability for commissioning maternity care across an integrated pathway remains with local CCGs, local authorities and NHS England. Local Maternity Systems will need to come to agreement as to how to commission against the local maternity transformation plan, including pooling of resource and joint commissioning, where appropriate (see chapter 6).

2.3.2 Developing a Local Maternity Transformation Plan

What?
By October 2017, the Local Maternity System should have established a shared vision and local maternity transformation plan to implement *Better Births* by 2020/21.

Local Maternity Transformation Plans will need to state how the Local Maternity System will deliver the following by the end of 2020/21:

- Improving choice and personalisation of maternity services so that:
  - All pregnant women have a personalised care plan.
  - All women are able to make choices about their maternity care during pregnancy, birth and postnatally.
  - Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.
  - More women are able to give birth in midwifery settings (at home and in midwifery units)[2].
- Improving the safety of maternity care so that by 2020/21 all services have:
  - Have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030.
  - Are investigating and learning from incidents and sharing this learning through their Local Maternity System and with others.
  - Fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Health Safety Collaborative.

How?
The plan will need to be co-produced with local service users, and should be agreed by the Local Maternity System and STP strategic partnership boards. It should be based on the following four considerations:

a) **An understanding of the local population and its needs from maternity services**. The local joint strategic needs assessment will bring together relevant information, as will the latest strategic needs assessment for maternity care and relevant other service areas, e.g. mental health. So that services are able truly to reflect the people they serve, Local Maternity Systems will want to consider the population profile, physical factors, e.g. transport, health deprivation and disability, the needs of culturally diverse communities and areas of multiple deprivation. They will want to consider the sources of data referenced in chapter 5.

b) An **analysis of the gap** between current service provision and the vision set out in *Better Births*. Local Maternity Systems will need to ensure this drills down to a sufficient level of detail to enable honest and accurate assessment (e.g., "Do we provide the type of personalised care planning envisaged in *Better Births?*", rather than "Do we offer personalised care plans?") and that it is based on service users' understanding of services (e.g., "Do women feel they are offered choice?", rather than "Do we offer choice?"). This will require qualitative and quantitative data on service user experience.

c) **Alignment with other local plans**. Local Maternity Systems should ensure that the strategic vision and objectives are aligned to the overall delivery of the STP. It will also be important to ensure that there is a consistent strategic vision between the local maternity transformation plan and the local health and wellbeing strategy and other plans.

d) **The financial case for change**, including overall affordability, transition and recurrent costs, assumptions about savings and how maternity transformation will contribute to the STP's financial balance.

In light of these things, the local maternity transformation plan should set out the vision for maternity services in March 2021 and how it will improve outcomes. The local maternity transformation plan should then map out what needs to be done to implement that vision. This should include:

- A clear statement from both a service and service user perspective on how services will be different once the plan is implemented.
- Actions and milestones, with responsible owners.
- How the plan will be delivered, monitored, assured, and evaluated.
- Interdependencies with other work streams of the STP (e.g. Local Digital Roadmap).

2 Evidence will be gathered from early adopters and other leading systems to consider whether more specific national ambitions should be put in place for the continuity of carer and midwifery birth measures during 2017. Local Maternity Systems are asked to begin to define and plan to meet local ambitions in these areas.

- Workforce development required to deliver the model of care.
- How the plan has been co-produced with service users and staff and how they will be involved in implementation.
- How key messages and updates will be communicated to key stakeholders and the public.

It is best practice to publish the local maternity transformation plan.

2.3.3 The Local Maternity Offer

What?
As part of developing the local maternity transformation plan, it is best practice to develop a Local Maternity Offer as a clear articulation to service users of the choice available across an integrated maternity pathway.

How?
The Local Maternity Offer is not a directory of services, but a way of describing how local services will Will deliver the *Better Births* vision for their community. The Local Maternity Offer should include the following:

- The range of universal antenatal, birth and postnatal services available across the Local Maternity System – and how to access them.
- The range of specialist services – fetal medicine, preterm delivery and neonatal care – and how to access them.
- The range of targeted services available for women who require additional support, including mental health services and support available to help women manage their health during pregnancy such as stopping smoking – and how to access them.
- The support available to enable women to make informed choices and develop their personalised maternity care plan, including how to access an NHS Personal Maternity Care Budget (where available), advocacy and interpreting.
- How continuity of carer will be delivered across the Local Maternity System.
- Further sources of information, including on local parent groups.
- The role of the Maternity Voices Partnership and how women and their families can become involved.
- How to provide feedback and make a complaint.

The Local Maternity Offer should be co-produced with service users, commissioners, providers and other key stakeholders.

The Local Maternity System should publish the Local Maternity Offer in formats that are readily accessible to the population they serve, including on a website, and ensure that the content is regularly reviewed and kept up to date. The Local Maternity Offer should be regarded as a living document that changes over time, in line with commissioning decisions that have come from the different stages within commissioning cycle.

2.3.4 Clinical and operational governance

What?
Clinical governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. [3]

Operational governance processes and protocols aim to ensure that patients get the right care at the right time from the right person and that it happens right first time.

Different organisations have different structures, processes and cultures and where they are not aligned, it can result in friction. Local Maternity Systems will need to align these by April 2018 to provide seamless care for women and their babies, and to break down traditional boundaries.

How?
Local Maternity Systems will need to determine the scope of their own governance, but will want to consider the following:

- Pathways – all maternity providers should know and understand the care available across the Local Maternity System. This will include knowledge of pathways of care available in midwifery units, obstetric units, neonatal services, perinatal mental health services, community hubs and other support services.

3 The national programme will make available an exemplar clinical governance model in Summer 2017, which can be used or adapted as required.

- Shared standards and guidelines, so that clinical teams across the Local Maternity System work to shared definitions of the care provided at different stages of each pathway.
- Transfer and referral protocols, so that it is clear what happens when a woman and/or her baby need to change pathway and/or receive care from another service or provider, including mental health services and specialist hospital services outside the Local Maternity System. It will need to include the role of community-based midwives who accompany a woman into a hospital.
- Other processes for how different organisations will interface with each other, e.g., access to hospital-based diagnostic equipment for community-based services.
- Record keeping – so that information can be shared between providers (in the longer term this should be electronic - see chapter 16).
- Shared learning, development and training – there should be consistent training across the Local Maternity System, which enables clinicians from different professions and different organisations to learn together.
- Shared staffing – in some Local Maternity Systems it may make sense to deploy clinicians across more than one organisation and there will need to be a policy setting out how this will work in practice. This will need to include support and management structures for staff, clear lines of accountability and handling of liability across organisations.[4]
- Review of data – clinicians from across the Local Maternity System need to come together regularly to review data, including patient experience data, both at Local Maternity System and unit level. This involves comparing and benchmarking, and using the conclusions to inform service improvement.
- When things go wrong there needs to be a consistent review and investigation process, and the Local Maternity System needs to ensure that the learning is shared.

Developing shared clinical guidance may not be straightforward, especially where organisations within a single Local Maternity System are currently operating to different standards and processes. It requires all organisations to work together to reach agreement on policies which ensure safety, whilst recognising the distinctive nature of individual services.

Agreements should be based on the best evidence available and have particular regard to NICE guidance in accordance with CCGs' and trusts' legal duties, as well as give consideration to guidelines and standards issued by the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the British Association of Perinatal Medicine. The Maternity Transformation Programme, following work with the Maternity Choice and Personalisation Pioneers, will publish example clinical governance arrangements across a locality. These will be made available to use or adapt as necessary.

As Local Maternity Systems become established and seek to develop their collaborative approach to commissioning and clinical governance, commissioners will need to consider how this can be reflected in maternity specifications and contracts. Commissioners may need to agree a standard set of wording that can be included in all maternity provider specifications and contracts to require providers to work collaboratively as part of a Local Maternity System. The Service Development and Improvement Plan (SDIP) within the NHS Standard Contract can also be used to identify specific improvement projects that seek to improve quality in a particular area (including by working collectively with other organisations).

Further sources of information

- NICE guidance
- RCM standards for midwifery services
- RCOG maternity service standards
- BAPM standards for hospitals providing neonatal care

4 Shared staffing is require amending contracts and terms of employment, and may therefore require negotiation with the appropriate staff side organisations.

3 Promoting safe and effective maternity care

3.1 What does *Better Births* say?

Most women who contacted the review said that the safety of their baby and themselves was their primary concern. They expected that the health services and professionals caring for them would also have safety as their priority.

3.2 What is the national programme doing?

In November 2015, the Secretary of State for Health announced an ambition to reduce the rate of stillbirths and neonatal and maternal deaths in England by 50% by 2030, as well as to target the number of brain injuries occurring during or soon after birth. It was supported by a national package of measures and funding, which included:

- An £8 million maternity safety training fund to support services to drive improvements in maternity safety.
- The launch of the 'Our Chance' campaign, targeted towards pregnant women and their families to raise awareness of the symptoms that can lead to stillbirth.
- A £250,000 maternity safety innovation fund to support local maternity services to create and pilot new ideas.
- The Maternity and Neonatal Health Safety Collaborative, to help services identify and implement quality improvement.

Further sources of information

Safer Maternity Care: Next Steps towards the national maternity ambition

3.3 What do Local Maternity Systems need to do?

What?
Local Maternity Systems should have safety at their core. Plans should set out how safety will be maintained and improved. Local Maternity Systems should provide a forum through which safety issues can be identified, solutions agreed and implementation of improvements overseen.

How?
Improving safety is not something that can be done as a standalone activity; rather it is something that must be hardwired into planning and delivering maternity services. Accordingly, this resource pack contains a number of activities throughout which will contribute to improving safety. Local Maternity Systems should:

- Build actions to improve the quality of care into their local maternity transformation plan and establish clinical governance so as to provide seamless care for women and their babies across organisational boundaries (chapter 2).
- Work with service users to ensure women's concerns are heard and acted upon (chapter 4).
- Continuously measure the quality of services and use the data to identify and implement service improvements. When things go wrong, ensure there is a rapid, consistent and high quality investigation, and swift learning across the Local Maternity System and beyond (chapter 5).
- Actively commission for safer outcomes (chapter 6).
- Ensure care is personalised around the needs of each woman her baby, and her family (chapter 7).
- Improve access to care through a Community Hub model (chapter 8).

- Improve safety through greater continuity of carer (chapter 9).
- Provide visible multi-professional leadership for a safety culture across its member organisations (see chapter 10).
- Improve and integrate elements of the pathway to improve outcomes, including prevention, mental health services, neonatal care and postnatal care (chapters 11 to 14).
- Ensure services have the right workforce to deliver safer care (chapter 15).

Further sources of information

The reports and programmes which will help Local Maternity Systems identify and implement actions to improve the safety of maternity care are:

- Safer Maternity Care
- Sign up to Safety
- Saving Babies' Lives care bundle
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)
- Each Baby Counts
- Maternity and Neonatal Health Safety Collaborative
- Avoiding Term Admissions Into Neonatal units (Atain)
- National Neonatal Audit programme
- Our Chance

Saving Babies' Lives

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

These elements were identified as such by experts through a process of engagement and consensus building over a 12 month period and in partnership with Royal Colleges, professional societies, charities, health arms-length bodies and government.

4 Co-production with women and their families

4.1 What does *Better Births* say?

Local maternity systems should be responsible for … ensuring that they co-design services with service users and local communities.

4.2 What is the national programme doing?

The national programme has commissioned the following advice to help Local Maternity Systems understand best practice in this area. A range of templates and toolkits for adaptation for local use, including a model terms of reference and a template for an annual report will also be made available on the National Maternity Voices website.

Further sources of information

National Maternity Voices

4.3 What do Local Maternity Systems need to do and how?

In a maternity context, the best way of instituting service user co-production is through a "**Maternity Voices Partnership**" (MVP). These are independent formal multidisciplinary committees which come together to influence and share in the decision-making of the Local Maternity System and its constituent parts. They are underpinned by practical support from local commissioners and providers, including appropriate financial support. They are similar to existing Maternity Service Liaison Committees (MSLCs) which they will replace.

4.3.1 Identifying the footprint(s)

What?
Local Maternity Systems will need to ensure all women in their area (and their partners and families) are able to participate in a Maternity Voices Partnership either by giving feedback or by becoming service user members of a partnership.

How?
Local Maternity Systems cover a relatively large footprint and it is unlikely in most places that local women and their families will readily identify with the Local Maternity System – especially if it means travelling long distances. Instead, they are likely to identify with a maternity or midwifery unit, or a Community Hub. Local Maternity Systems need to recognise this and establish channels which work for local women and their families. In practice this will most likely mean establishing more than one Maternity Voices Partnership around smaller footprints. This will also enable service users, CCGs and/or providers to work together on issues related to the individual CCG or provider. Effective user engagement is something that is built up over time. In some areas arrangements already exist, such as MSLCs. Where possible these should be built upon.

Local Maternity Services should ensure active involvement of Maternity Voice Partnerships in developing their plan The model for achieving this is best determined locally in consideration of the area's geography and service structure. The strategic partnership board of the Local Maternity System should include Maternity Voices Partnership representation.

4.3.2 Establishing Maternity Voices Partnerships

What?
Maternity Voices Partnerships will need to establish a committee structure.

How?
The partnership will need to bring together representatives from a wide range of organisations. The exact membership will be for local areas to determine, but they will want to consider the table below.

Potential membership of a Maternity Voices Partnership	
Maternity service users and families (should constitute at least a third)	Maternity Voices Partnerships will want to promote themselves widely. They will also want to ensure that the service user members are representative of the diversity of the local community.
Charities and advocacy groups	Maternity Voices Partnerships may want to invite organisations representing local women. Their role is likely to be particularly important in ensuring the voices of seldom heard and vulnerable women are heard. To ensure continuity of input and effective communication it is helpful to have named individuals who can attend the partnership regularly.
Commissioners	Representatives from all commissioning organisations within scope (including, where appropriate, local authority and specialised commissioners) will want to participate. Again, it is helpful to nominate a consistent lead.
Providers	Representatives from all local providers (including, where relevant, mental health providers, ambulance services and independent midwifery practices) may want to participate. They should also be encouraged to nominate a consistent lead.
Statutory partners	This will include Healthwatch – the local statutory organisation with a particular role in co-ordinating the voices of service users. Others including NHS England, NHS Improvement and Health Education England may also be able to provide advice.
Clinical and managerial representation from a cross-section of clinical professions	The partnership will want to consider midwives, obstetricians, neonatologists/paediatricians, and perinatal mental health specialists so as to ensure effective clinical engagement, as well as from management, including financial management.

The governance should be set out in terms of reference which are agreed by the Maternity Voices Partnership and ratified by the Local Maternity System Board, and/or by relevant commissioner(s) and provider(s), so that there is a shared understanding of the role the partnership will play.

When establishing the terms of reference for the Maternity Voices Partnership, it will be important to review the impact and effectiveness of current models of engaging women and their families on shaping local maternity services. Many areas will have MSLCs that have been in operation for a number of years and it will be important to build on their work, experience and membership. Existing MSLCs should change to be known as a Maternity Voices Partnership.

The terms of reference may need to contain:

- Core purpose.
- The means by which it will deliver its core purpose, i.e. the kind of activities it may undertake.
- Behaviours – expectations of how members of the Maternity Voices Partnership should work with each other.
- Rules for appointing the chair.
- Accountability and lines of reporting.
- Decision-making processes.
- Practicalities for meetings.

Further advice is provided at Annex B.

4.3.3 Actively commissioning a Maternity Voices Partnership

What?
A Maternity Voices Partnership should have a defined programme of work and be adequately resourced.

How?
This means ensuring that it delivers an annual or multi-year programme of work, in return for which appropriate funding is made available. It works best when it is in line with the business planning cycle of the partner Local Maternity System, commissioner(s) and/or provider(s). It will need to be agreed by the Maternity Voices Partnership and ratified by the Local Maternity System, commissioner(s) and/or provider(s) so that there is a shared understanding of what the Maternity Voices Partnership will deliver. The programme of work should be costed at the outset, and any resources required should be negotiated to implement it with the partner Local Maternity System, commissioner(s) and/or provider(s).

Funding may be required for:

- Remunerating the chair (for both chairing the partnership and, where relevant, representing the Maternity Voices Partnership at Local Maternity System level). It is best practice for the chair to be remunerated to reflect the skills, experience and time commitment required for the role.
- Providing the secretariat.
- Paying the expenses of the service user members, including childcare costs.
- Training for service user members.
- Intelligence gathering to support the work of the Maternity Voices Partnership.
- Commissioning research.
- Communications activities, including engagement and outreach.

A simple way of facilitating this funding is to provide the Maternity Voices Partnership with an annual budget, although it may be supported through providing access to NHS staff and/or facilities.

The maternity commissioner is responsible for facilitating and organising any agreed funding, whether provided by the commissioner alone or in conjunction with local providers. Local discussions will need to take place to agree how the costs of the Maternity Voices Partnership will be shared between commissioner and provider organisations. In terms of maternity providers, this may require an amendment to the existing contract to ensure providers financially contribute to the Maternity Voices Partnership and are able to release staff to engage with the Maternity Voices Partnership.

Further sources of information

- NHS England has produced a guide, Transforming Participation in Health and Care
- The Coalition for Collaborative Care has produced a Co-production Model, which includes five values and seven steps that can be used by Local Maternity Systems to develop their strategic approach to promoting co-production

Bromley Maternity Voices (MSLC) is a multidisciplinary committee. One third is made up of service user representatives and current service users, with lead midwifery managers, including the Head of Midwifery, commissioners, health visitors, student midwives, obstetricians, neonatologists, GPs and anaesthetists also being represented The committee has links to Healthwatch and Public Health England. The chair is a service user representative. The full committee meets six times a year; four times during the day in local children and family centres, twice a year in the evening at the local maternity unit. It is generally attended by between 15 and 30 people.

Bromley MSLC oversees, plans, develops and monitors maternity services in the borough of Bromley. It is linked to the local maternity unit run by King's College Hospital NHS Foundation Trust, community hubs, local children and family centres and GP practices. It is independent from but maintained by Bromley CCG, which provides administrative support, a free crèche and travel expenses for service users, printing and publicity costs and an honorarium for the chair. It is part of the South London MSLC Network, a group of 10 MSLCs. Chairs of the committees meet regularly to share best practice and support each other.

Service user representatives of Bromley MSLC sit on the quarterly Bromley CCG Joint Maternity Commissioning Group meetings as well as local monthly Labour Ward Forums. They monitor developments at commissioning and provider level.

Bromley MSLC regularly "Walks the Patch" on the maternity wards and in the community, talking to women and their families about their experience of maternity care, including young and vulnerable women.

5 Measuring, reviewing and improving service quality

5.1 What does *Better Births* say?

If teams, organisations and systems are to improve, they must know where they are, how they compare to others and to the best, and how they are improving over time. Collecting the right information and making the best use of it is therefore vital.

5.2 What is the national programme doing?

Better sources of information will be made available to help Local Maternity Systems better understand the quality and efficiency of the service they provide, including:

- The **Maternity Services Data Set** captures key data from NHS-funded maternity services. Based on feedback received during the National Maternity Review, the national programme is working to revise the data set to ensure that it contains the most relevant and useful data possible. In addition, NHS Improvement and NHS Digital are working hard to improve the data quality.
- A set of 14 metrics that could be scrutinised monthly and used for **clinical quality improvement** work at a local level have been developed with stakeholders (see Annex C). During 2017, NHS Digital will start to publish the metrics using their iView tool allowing providers to compare their performance and identify where they are an outlier.
- Insight on what women think about their care is captured through the Care Quality Commission's (CQC) **Maternity Experience Survey**. The national programme is working with CQC to ensure it includes useful data to support local maternity service transformation.
- In addition, a set of **National Maternity Indicators** is under development. These will provide a more holistic assessment of maternity services using data from annual surveys and the National Maternity Perinatal Audit. The first iteration will be available by the end of 2017 but the indicators will be developed over subsequent years as new data sources become available.
- The National Child and Maternal Health Intelligence Network's (ChiMat) website hosts a range of **public health** tools that will support Local Maternity Systems understand the needs of their populations.
- A new **National Maternity Data Viewer** tool is being developed for use in 2018. This will present descriptive data such as activity and demographics, the Clinical Quality Improvement Metrics and the National Maternity Indicators together as a dashboard. The data will be presented using a balanced scorecard approach at CCG, Local Maternity System and maternity Clinical Network levels and show rates of change and unwarranted variation. The format will enable comparison with peers and the national average.
- **NHS Rightcare** has produced a range of tools and resources based on national datasets to help commissioners identify unwarranted variation, including in maternity. The national programme will work with Rightcare to take account of the new data sources and indicators.

The **CCG Improvement and Assessment Framework** contains four indicators relating to maternity services:

- Neonatal mortality and stillbirths.
- Women's experience of maternity services.
- Choices in maternity services.
- Maternal smoking at the time of delivery.

Each year a snapshot assessment on the performance of each CCG will be published, based on these indicators and drawing on wider measures. The insight from these ratings will inform the support offer to each Local Maternity System.

Further sources of information

- How to implement the Maternity Services Data Set and submit data
- Maternity Experience Survey
- National Child and Maternal Health Intelligence Network
- NHS Rightcare website
- More detail on the CCG Improvement and Assessment Framework
- More detail on the maternity assessment and the NHS England support offer
- Details of individual CCG performance

5.3 What do Local Maternity Systems need to do and how?

Local Maternity Systems will need to ensure they are collecting the right information, but, most importantly, make best use of it to improve services.

5.3.1 Making use of national data sources

What?
Local Maternity Systems will need to participate in and make active use of the nationally-developed data collections and tools (as and when they come on stream).

How?

- Local Maternity Systems will need to pay particular attention to making improvement against the indicators included in the **CCG Improvement and Assessment Framework**. Being an outlier on these measures should be a trigger for a more detailed system wide investigation.
- The capability of the **Maternity Services Data Set** to provide useful information about maternity services is dependent upon all providers submitting high quality, complete data each month. Local Maternity Systems should ensure this priority is acted upon.
- Local Maternity Systems should review data against the Clinical **Quality Improvement Metrics** and track changes over time so as to identify areas for quality improvement work. This will require using in-house data until NHS Digital begins publication during 2017. Similarly, Local Maternity Systems should use the **National Maternity Indicators** to identify areas for improvement once they are available, and **public health data** available through ChiMat. Until the data viewer is available, Maternity Clinical Networks have developed their own dashboards and Local Maternity Systems will want to continue using these.

5.3.2 Service user data

What?
Maternity services will need to use service user feedback to inform local transformation.

How?
Local Maternity Systems should work with their Maternity Voices Partnership, who will be able to play a leading role in capturing and interpreting local data on service user experience.

They should start with an analysis of results from the Care Quality Commission's Maternity Experience Survey and the Maternity Friends and Family Test. The two can be used at together, along with other local engagement and feedback, to build a comprehensive understanding of women's experiences.

The Maternity Experience Survey results can be used to map change over time, assess the impact of new initiatives or to tackle health inequalities. The results can be used to compare and contrast results with other similar size and type service providers, the national average, or the top and bottom performers. This can be particularly useful to identify benchmarking partners or to 'buddy' organisations that are performing well with organisations looking to improve. Exploring issues that other organisations, facing similar problems, have successfully tackled may identify transferable solutions and some "quick wins".

Local Maternity Systems can also use more in-depth methods to understand why people have given the answers they have in the national surveys. These include local surveys, focus groups, experience-based co-design (a process in which people's stories about their experiences are used as the basis for small group work to co-design solutions to the issues that have been raised) and developing "always events" (aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time). These means can enable providers to see what their service feels like from different perspectives, and will highlight any variation, reasons for this variation and how services could improve. Data from compliments and complaints will also support Local Maternity Systems with insight into how effective the current maternity pathway is in meeting the needs of women, their babies and families.

Local Maternity Systems should ensure that they capture insight from the full range of service users. This may include developing bespoke strategies to reach certain mothers including mothers who experienced loss. Work conducted by Sands (the stillbirth and neonatal death charity), on this topic confirmed that seeking real time feedback from women in this situation is not appropriate[5]; instead, teams could consider alternative timing; working with bereavement specialists and / or engaging women to talk about their experiences as part of a reflective exercise.

What staff think about the care they provide can act as an early indication of issues impacting on service user experience. The NHS staff survey can therefore be used to explore responses from midwives (and depending on locally available breakdowns of the data) other relevant staff, about their experience of caring for women on the maternity pathway. Similarly, responses from the Staff Friends and Family Trust can be used to explore staff experience more regularly and in greater depth, alongside other mechanisms such as focus groups and workshops, so that staff as well as women can be heard and listened to – with subsequent actions having positive impacts on both staff and service user experience.

Further sources of information

- Friends and Family Test
- Experience-based co-design
- Always events

5.3.3 Reviewing data

What?
Local maternity systems will need to develop a strategy for using data to monitor, review and improve services.

How?
The data strategy should describe ways to use data to:

- Understand how the Local Maternity System is used (e.g. analysing choice, patient flow, staffing).
- Identify and address trends outliers/ unwarranted variations in outcomes, and reasons for them.
- Identify opportunities for service improvement.
- Identify opportunities for efficiency savings.

The data strategy should identify which data should be used for the different levels of the system, i.e., data that makes sense to review on a Local Maternity System basis may not useful for a provider unit/team. The data strategy will also determine the appropriate frequency at which data should be reviewed. It will make sense to review some data daily or weekly, whereas some should be reviewed monthly, quarterly or annually.

Sufficient time and resource should be provided for routine and regular data review. This should be built into clinical and operational governance as described in chapter 2.

5 https://www.sands.org.uk/about-sands/media-centre/news/2013/12/sands-supporters-impact-nhs-england-customer-service-survey

Clinical audit and peer review are an integral part of delivering effective clinical governance as set out in Chapter 2. They will provide Local Maternity Systems with detailed insight into what is going well, what is not, and what needs to change.

Further sources of information

- What is clinical audit?
- Patterns of maternity care in English NHS Trusts

5.3.4 Learning from incidents of harm to prevent recurrence

What?

Responding appropriately when things go wrong in healthcare is key to continually improving the safety of the services we provide to our patients. Recognising, reporting and investigating Serious Incidents, taking effective targeted action to implement learning, and ensuring a robust mechanism to share learning across the Local Maternity System so as to prevent recurrence of harm is critical to improving the safety of maternity services.

Local Maternity Systems will need to review how this is done and identify where improvements might need to be made to ensure it is done consistently and to a high standard, in line with national guidance.

How?

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great that a heightened level of response is justified. The Serious Incident Framework describes the circumstances in which such a response may be required. The Serious Incident Framework also describes the method for undertaking an investigation for the purpose of learning within the NHS – referred to as Root Cause Analysis (RCA). This method, when undertaken by those with appropriate skills and resources, systematically identifies how and why incidents happen. Analysis is used to identify causes and to develop recommendations which address these in order to deliver safer care for service users in future.

The needs of those affected should be the primary concern of those involved in the response to and the investigation of Serious Incidents. Patients, families and carers must be involved and supported throughout the investigation process. They must have clear expectations about the process and how they can be involved from the outset. The investigating organisation should assign an appropriately trained point of contact for the patient and/or family and there should be regular communication throughout the process. The Serious Incident Framework contains further information.

Not all incidents will meet the threshold of a Serious Incident. However, all Patient Safety Incidents[6] (regardless of severity) should be reported on to local risk management systems and uploaded to the National Reporting and Learning System (NRLS)[7] to assist both local and national learning and safety improvement.

Sufficient resources will need to be made available for the implementation of recommendations, and activities should be monitored to ensure changes are effectively delivered and achieve the improvements and risk reduction intended. Recommendations should also be considered as part of an organisations overall safety strategy so that actions are not taken in a fragmented and unsustainable way.

Further sources of information

- Serious Incident Framework
- Tools and guidance for undertaking RCA investigation

6 Patient Safety Incident: Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS-funded healthcare

7 https://www.england.nhs.uk/patientsafety/report-patient-safety/

8 NB: while tools and resource provide a helpful guide, they do not overcome the need for training which must offer a practical element (particularly in relation to analysis of how and why problem occur). Training courses should: follow and promote the Serious Incident framework; follow and endorse the NPSA guidance and toolkit; specifically promote the use of the NPSA final report templates. The NPSA guidance on: human error, fair blame, human factors, cognitive interviewing, being open and effective solution generation and implementation should all be part of the courses for all of the above.

6 Commissioning for outcomes

6.1 What does *Better Births* say?

Commissioners need to take clear responsibility for improving outcomes and reducing health inequalities, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly.

6.2 What is the national programme doing?

Improved data tools to interpret the data will be made available as detailed in the previous chapter. In particular, NHS England is shining a light on maternity outcomes through the CCG Improvement and Assessment Framework.

Some of the Early Adopters are developing new models of commissioning for outcomes and we will share this as they are developed over the coming months

Further sources of information

There is a growing body of general evidence on how to commission service transformation which will also be useful in the maternity context. This has been brought together in NHS England's document *Commissioning for effective service transformation: What we have learnt*: **https://www.england.nhs.uk/wp-content/uploads/2014/03/serv-trans-guide.pdf**

6.3 What do Local Maternity Systems need to do and how?

In common with commissioners of other services, Local Maternity Systems will need to move from a traditional service- specific approach, to one that is outcome focused and place based.

6.3.1 Identifying outcomes

What?
The first step is for Local Maternity Systems to identify and agree the outcomes that require improvement.

How?
The process to identify outcomes should be clinically-led and co-produced with service users. As set out in chapter 2, Local Maternity Systems should start with an analysis of the needs of their population, the extent to which they are being met by current services and the extent to which they currently deliver the *Better Births* vision, before considering the service transformation the Local Maternity System aims to achieve. The data described in the previous chapter will provide sources on which to base this analysis, although local audits may be required for some measures. The different outcome types Local Maternity Systems might want to consider are:

- Direct clinical outcomes which local providers agree to work together to improve (e.g., perinatal mortality).
- Public health outcomes whereby NHS and public health providers agree to work together to ensure there is a change to health behaviour (e.g., maternal smoking).
- Woman-reported outcomes whereby providers work together to change the way women feel about the care they have received as evidenced through formal feedback (e.g. a survey).
- Process outcomes whereby providers work together to change the way a service is provided (e.g., the number of women giving birth in midwifery settings).

Local Maternity Systems will in particular want to consider what outcomes are most important to service users. A tested method of doing this is to use *I Statements.* These take a service user perspective to voice what a good service looks like. Generic *I Statements* have been developed by National Voices and Think Local Act Personal to inform local planning and co-production events. Local Maternity Systems may want to consider developing something bespoke for maternity. Many maternity services have

undertaken workshops to enable different members of the team to put themselves in the position of service users and work through different scenarios.

Local Maternity Systems may want to pay attention to sectors of the population who are more likely to experience poor outcomes to ensure that local transformation has an impact on reducing health inequalities.

Further sources of information

A narrative for person-centred co-ordinated care

6.3.2 Commissioning for improvement

What?
Once the outcomes have been identified, Local Maternity Systems will need to develop an approach to commissioning against the outcomes.

How?
Local Maternity Systems will need to develop a series of performance indicators from the outcome measures. These can be written into the maternity specification and used for performance management.

To ensure that the outcome measures identified can be used to drive improved performance, Local Maternity Systems will need to consider:

a. Setting a level of ambition for each indicator alongside a timeframe for achieving it. This needs to be realistic and affordable. It may require delivery over a series of phases, especially where the ambition is high.
b. Understanding what model of service delivery is required to deliver the improved outcome, and what is required to underpin it, i.e.:
   - What service each provider will make available, any changes (investments or disinvestments) this may mean to the existing service offer and the timescale for making these changes.
   - What the workforce requirements are, and how any changes to the deployment of workforce will be managed, including identifying training needs and building capacity to improve outcomes.
   - How much it will cost to deliver the new model and then to run it once delivered, and identifying these resources.
c. What support the service needs from commissioners to empower the Local Maternity System to make changes. This should include accessing elements of the bespoke support offer made by national, regional and maternity Clinical Network teams, including where appropriate access transformation funding.
d. How to incentivise improvements.

6.3.3 Contracting models for place-based outcomes

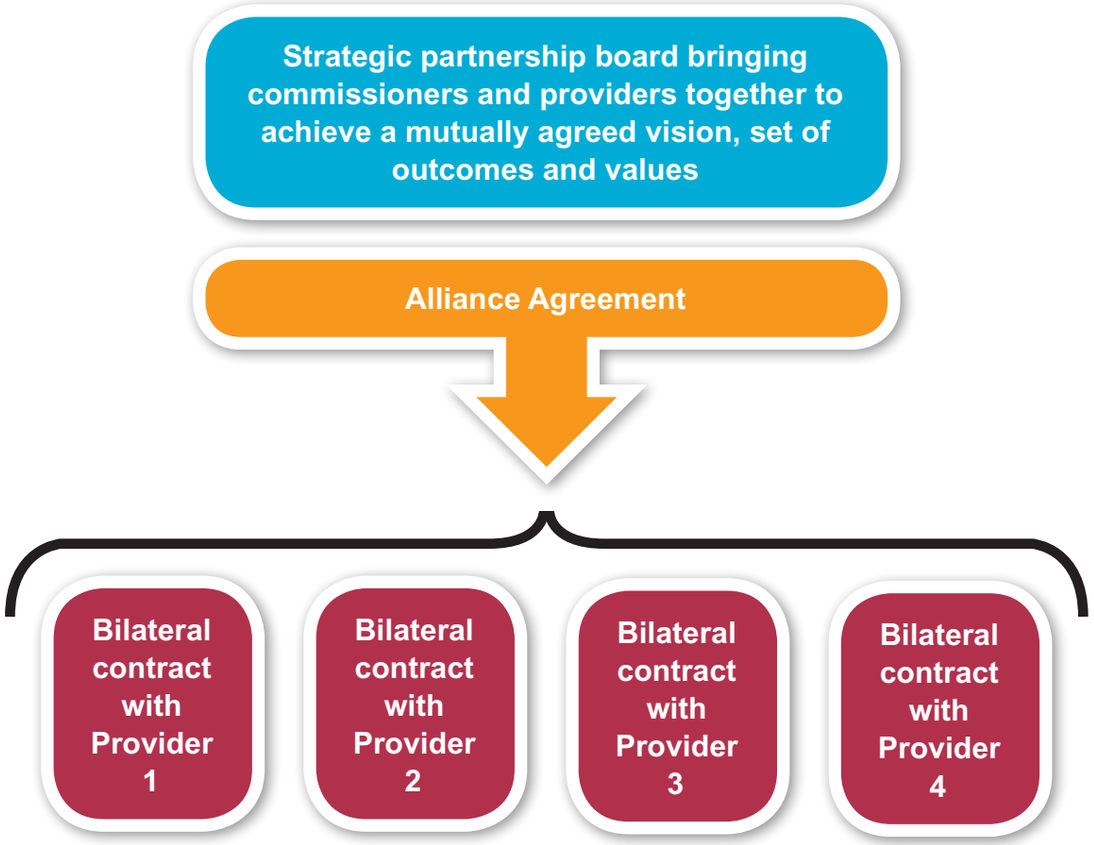
What?
Possible approaches to contracting maternity providers include: an NHS Standard Contract, an Alliance Agreement or an Accountable Lead Provider / Prime Contractor contract. They will need to decide which works best locally to secure improvement against outcomes. The latter two have been increasingly used by CCGs and local authorities to provide a governance mechanism for bringing multiple providers together, although they are still in their infancy within the NHS.

How?
The **NHS Standard Contract** enables an NHS commissioning body to enter into a bilateral contract with a provider to deliver the whole maternity pathway, or elements of it. This is the traditional way of commissioning NHS maternity services in England. The Maternity Pioneer programme will make available an exemplar service specification which will be available to commissioners to adapt to their local requirements, when it is developed in the coming months.

If commissioners take this approach, they will need to specify in individual contracts each provider's contribution to the service model and to transformation, as there is no collective responsibility.

An **Alliance Agreement** brings providers together who already have an existing bi-lateral contract with a commissioner to enter into a new partnership to work collaboratively on achieving a defined set of outcomes for a specified population group or an integrated model of care. It can include public health providers.

The governance arrangements of an Alliance agreement



Alliance agreements are built upon trust and significant time is required up front to develop strong relationships and partnership working. The Alliance Agreement would need to specify how risk sharing would work and the implications for the partnership should one of the providers fail to deliver their aspect of the agreement. Alliance agreements often have a no dispute clause, to promote collaboration and eliminate use of the courts to resolve disputes.

Flexibility should be made within the Alliance Agreement to allow new entrants to the market to join the partnership agreement, such as independent midwifery practices.

Under an **Accountable Lead Provider / Prime Contractor** contract the lead provider / contractor will be commissioned to deliver all or a significant element of a new model of care and a defined set of outcomes. They may well have to subcontract elements of the pathway to other providers. This can include new entrants to the market such as independent midwifery practices. Instead of the risks of achieving the outcomes and new model of care sitting with a range of providers, they remain with the lead provider / contractor. This approach gives them considerable flexibility in how the outcomes are achieved and the new model delivered. This approach can also lead to benefits in terms of an integrated approach to workforce training and development, information governance and integrated IT systems.

Further sources of information

The Department of Health recently commissioned a literature review from the London School of Hygiene and Tropical Medicine's Policy Research Unit in Commissioning and the Healthcare System: Alliance contracting, prime contracting and outcome based contracting; what can the NHS learn from elsewhere?

7 Choice and personalisation

7.1 What does *Better Births* say?

Women's maternity care should be personalised to their needs and those of her baby and family. Every woman is different, and will be starting from different places – some may be first time mothers, others may have had babies before. Some will be very young, others at the older end of the childbearing period. Some will have childcare to worry about. Some will have support from family nearby, others will not have any support.

Women should be able to make decisions about their care during pregnancy, during birth and after their baby's birth, through an ongoing dialogue with professionals that empowers them. They should feel supported to make well informed decisions through a relationship of mutual trust and respect with health professionals, and their choices should be acted upon.

Personalisation means … The development of a personalised care plan by the woman and midwife, built on the decisions each woman makes, and informed by an assessment of the type of care she might need. This will accommodate the risk involved, which recognises that risk is not binary or absolute, but seeks to accommodate that risk. The woman will have an honest, open and unbiased dialogue with health professionals, supported by evidence based information being available about their choices which are easily accessible. There must be sufficient time to have this dialogue.

7.2 What is the national programme doing?

A pilot scheme called the Maternity Choice and Personalisation Pioneers is testing out ways of improving personalisation. The models and approaches that they develop will be made available as a resource to draw from, alongside a range of templates and toolkits developed centrally to support the Pioneers, as they become available over the coming months.

In particular, the Pioneers are testing Personal Maternity Care Budgets. A Personal Maternity Care Budget is a tool through which women can give effect to the choices they make. Pioneers are testing different models of Personal Maternity Care Budget and different approaches and mediums for capturing a woman's choices.

In addition, analysis will be undertaken during 2017 using evidence gathered from the Pioneers and the Early Adopters to consider whether a more specific national ambition should be put in place to expand midwifery births. Further guidance will be issued once this is complete.

Further sources of information

→ Personal Maternity Care Budgets and the Maternity Pioneers

7.3 What do Local Maternity Systems need to do and how?

Local Maternity Systems will need to ensure that there is a range of providers, offering a range of styles of care, whilst at the same time these providers are safe and sustainable.

At the same time, Local Maternity Systems need to make sure that women have the tools and support available to help them make and give effect to informed decisions about their care.

7.3.1 Reviewing the current offer and improving it

What?
Local Maternity Systems will need to review the current choice offer across the footprint, consider whether this meets the recommendation in *Better Births*, and draw up plans to improve it.

How?
The Maternity Pioneer programme developed a baselining template to capture the choice in place across Pioneer areas. This can be used for a Local Maternity System and can be found in 'Further sources of information', below.

Local Maternity Systems will in particular want to ensure that any current barriers restricting choice within the Local Maternity System (e.g., providers restricted to operating in just one CCG footprint) are removed. It is also best practice to agree protocols with neighbouring Local Maternity Systems so that women, particularly those who live near the boundary, can access services in neighbouring areas. The baseline should capture all the providers with which the Local Maternity System has a contractual relationship, even if these are outside of its footprint.

A gap analysis can then be conducted, enabling Local Maternity Systems to identify how services should be configured to satisfy demands for both safety and access. Some key considerations will be:

- The demographics of the Local Maternity System, e.g., population increases owing to planned housing development, or areas of multiple deprivations.
- The geography[9] of the Local Maternity System, particularly ease of access, i.e., roads and public transport routes.
- The demand and capacity of existing maternity services across the area, including where women are choosing to access maternity care in neighbouring areas.
- Current and potential approaches to offering midwifery (including homebirth) services in light of the implication that, if supply better matches the choices women say they want, more births will take place in midwifery units and at home. Local Maternity Systems will need to ensure that services are able to support this.
- The local case mix, in particular bearing in mind that the national trend is for more complex care.
- Access to support services, including paediatrics/neonatology and anaesthetics.
- The financial case for change, including overall affordability, transition and recurrent costs, assumptions about savings and how the transformation will contribute to the STP's financial balance.
- Local supply of the clinical workforce required to staff services safely, and approaches to workforce deployment, training and development, including the use of maternity support workers to provide additional capacity and choice within the maternity pathway.
- Specific plans can then be put in place to address the identified gaps, which should be included in the local maternity transformation plan and used to keep the local maternity offer up to date.

Local Maternity Systems will want to repeat the gap analysis exercise as services change and develop, taking into account feedback from women and their families.

Social, clinical or behavioural factors such as domestic violence, mental health or smoking will impact on the number of women able to choose the care they would like. Tackling these will require upstream measures.

Further sources of information

- Securing meaningful choice for patients: CCG planning and improvement guide sets out enablers for patient choice, and the actions that can be taken to deliver these
- Maternity choice baselining template

7.3.2 Extending choice

What?
The gap analysis may indicate that new services need to be commissioned in one or all of the parts of the maternity pathway. Once the Local Maternity System has worked out what the choice offer should be, it will need to find provider(s) to deliver it.

How?
Market Position Statements have been widely used by local authorities for many years to provide clarity around future commissioning intentions and to stimulate the provider market. However, they have not been so widely used within the NHS. The gap analysis

9 *Better Births* recognised that there can be particular challenges in commissioning safe and sustainable services in remote and rural areas and suggested some innovative working practices and ways of deploying staff to improve sustainability.

could be used to form a market position statement, which will enable Local Maternity Systems to define:

- The range of services women, their families and babies need.
- The new model of care and what needs to change over the next few years to achieve it.
- The commissioning process to procure new entrants to the market and the maternity pathway tariff structure.
- How providers can engage in discussions with commissioners.

There may be opportunities for maternity Clinical Networks to support Local Maternity Systems to work collaboratively on a regional basis to reflect the fact that women may choose to access services in a neighbouring Local Maternity System area and that some specialist maternity services are commissioned at a regional level.

Once there are multiple providers operating within a system, especially if the choice is not primarily between two similar services which operate from different geographies, the initial access to maternity service and the choice conversation needs to be considered. One model which aims to provide women with a clear and even handed offer of all the options available for them is a single point of access, staffed by independent professionals or by a combination of professionals from each provider. This approach is planned by some of the Maternity Pioneers and Early Adopters and case studies will be made available.

7.3.3 Working with independent Midwifery Practices

What?
Early learning from the Pioneer areas shows that, although the introduction of an independent midwifery practice can make an important and valued addition to the choices available to women, there are a number of barriers that need to be addressed to support their introduction to a Local Maternity System.

How?
There should be a clear approach as to how the new provider will work with the existing, in particular, acute providers. If the new provider needs to sub-contract elements of the antenatal pathway, for example scanning, this needs to be made clear in the contracting and the Local Maternity System can work together to identify appropriate parties available for these elements. The referral pathways between providers need to be clear and consideration could be given to the payment flows between providers and an agreed process for any dispute concerning cross-charging.

Some of the Pioneer areas are testing different payment models to address some of the barriers to independent midwifery practices and look at risk sharing between the parties involved in the provision of care. These will be written up and shared as the learning from them develops.

The key commissioning considerations for working with a independent midwifery practice are:

- Any sub-contracts required for elements of the pathway;
- Shared clinical and operational governance as detailed in chapter 2.
- Processes for submitting antenatal and newborn screening data.
- Commissioning of @nhs.net email addresses for the provider and consideration of access to N3.
- Data reporting requirements to the Local Maternity System.

Further sources of information

- Think Local Act Personal resources on developing Market Position Statements
- Information and resources from Oxford Brookes University

7.3.4 Capacity and sustainability

What?
Local Maternity Systems will want to ensure that there is sufficient capacity to meet local demand for midwifery services as part of ensuring that a choice of homebirth, midwifery unit and obstetric unit is available. However, some commissioners report difficulty with commissioning financially sustainable midwifery services. They find that low numbers of women choosing these services has resulted in high unit costs.

How?
There are a number of approaches that can help resolve such issues:

- Empowering women to make choices in line with NICE guidance (as set out in this document) is likely to lead to more women choosing midwifery care.
- Ensuring that organisational boundaries do not restrict choices within and between Local Maternity Systems.
- Co-locating midwifery units with Community Hubs (as set out in chapter 8) and staffing them with community midwives means that the extra costs of providing birthing rooms will be small.
- Operating innovative staffing models can provide high quality and efficient services, for example making optimal use of the Maternity Support Worker role.
- Operating a “pop up” midwifery unit means that the community-based midwives can lock up and leave unused units and return to other duties.
- Considering the location of services carefully to provide the largest catchment area.

7.3.5 Information for women

What?
In order for a woman to feel supported and empowered to make choices about her maternity care, she needs to be provided with clear and accurate information that supports the choice offer available to her.

How?
Local Maternity Systems will need to review and quality assure the information they make available to women to help them make choices including as part of developing a Local Maternity Offer (see chapter 2). The Pioneer programme is conducting a national survey and working with a group of clinicians to produce a quality standard checklist for the provision of information. This will also be supported by a toolkit for professionals, to support the person who is having the choice conversation with a woman and to ensure that have the information that they require for that conversation. These will be available nationally in the summer of 2017.

7.3.6 Personalised care planning

What?
All women should have a personalised care plan built on the decisions she makes. Best practice is for it to be based on free text; a checklist approach can restrict thinking and lead to pre-determined pathways based on standardised answers, although checklists can be helpful as a reminder of the questions to consider whilst the plan is being drawn up. It should be owned by the woman and shared with her clinicians to help them understand her decisions.

How?
A woman’s personalised maternity care plan should record:

- What is important to the woman and her family. This may include anything, but is likely to include:
  - Her values and expectations about being pregnant, giving birth and becoming a mother.
  - Her home/family/professional life and support networks.
  - Her previous experiences of pregnancy and childbirth.
  - Any fears or concerns she might have.
- Record the health needs of the woman and her baby. This should be an assessment of the care she is likely to need based on her underlying state of health (including pre-existing conditions) screening and diagnostic tests, and her experience of this and previous pregnancies. It is essential for safety. It should always take account of the mother’s mental health and of opportunities to improve her underlying health and thereby give her baby the best start in life.
- It should then set out the decisions she makes about the care and support she wants to receive taking into account the information above, and including any mental healthcare she might need. It should reflect the woman’s decisions about location of care, particularly where to give birth and methods of pain management to be used during labour. It should record a plan B, i.e. what happens if a (further) complication arises.

The exercise should be undertaken for antenatal, intrapartum and postnatal care, but it is not necessary to complete all three sections at once. Indeed, it is best practice for the woman to take time to reflect and for her needs and wants to crystallise before attempting to complete the intrapartum and postnatal sections. It is, however, sensible

to discuss postnatal care some time before the birth so as to encourage the woman to plan for caring for a baby (although it will need to be reassessed after the birth) in any case, it is important to keep the personalised care plan up to date as her pregnancy progresses and take into account assessments around risk and the mother's and baby's health and wellbeing.

The personalised care plan provides an ideal opportunity to develop strategies to help each woman manage her own health and in so doing ensure the best outcome for her baby. The personalised care planning should consider what action the woman may need to take with regard to smoking, diet and use of alcohol. It should also set out what support she might need to help her take those actions.

7.3.7 Supporting women with her personalised maternity care plan

What?
All women should be offered help to draw up and develop her personalised care plan and make her choices through discussion with a clinician. This should not be a one off discussion; rather it is a process that begins with the first antenatal appointment and continues into the postnatal period. The process needs to recognise that different women will want different levels of support and be ready to make decisions at different times, and many women will begin to make choices before they first meet a clinician (e.g. about their choice of antenatal provider).

The support should involve discussion between the woman and the professional who is providing the ongoing co-ordination of her care. This is normally her midwife, but in some circumstances it may be an obstetrician. In any case, the clinician should have the right skills and the right training to undertake this discussion.

The discussion should recognise that a key driver of a woman's decisions about her and her baby's care during pregnancy, childbirth and the postnatal period will be her personal values and previous life experiences. That being the case, it is recommended to start with the woman's expectations and this should be on the basis of open questions that allow the woman to express herself. It may be helpful to ask the woman to complete a questionnaire about herself and her expectations ahead of the discussion, so that she has an opportunity to reflect on the issues.

The conversation should take full account of a woman's personal and social circumstances, including her family and support networks.

If the woman has a partner or friend whom she wants to accompany her to antenatal appointments and/or the birth, that person should be encouraged and supported to support the woman. However, some women will not want this and that must also be respected.

The discussion should also take account of other important factors, such as care for other children or other relatives, employment and lifestyle, but should not lead to judgements about the way a woman chooses to live her life. If the discussion highlights safeguarding risks the midwife or the obstetrician should follow local safeguarding policies and procedures.

The conversation should take account of the woman's own and family history, both of pregnancy and birth and of any medical issues in her family. It will be crucial to identify whether the woman has a pre-existing condition, what impact this might have on her maternity care, and additional care she may need to manage her pre-existing condition. This will need to take account of information supplied by the woman's GP and/or specialist doctor. Where appropriate a complete and co-ordinated package of care should be built around the woman's needs to support her to manage both her pregnancy and her pre-existing condition. In the same way, consideration should be given to the impact on care for the baby.

Consideration of the mental health of the woman and partner should routinely be built into the conversation in the same way as physical health, including any previous history of mental health conditions. An appropriate assessment should be made and, where appropriate, the woman should be offered a referral to support services.

The conversation should take account of the result of screening and diagnostic tests undertaken as part of the pathway.

Local Maternity Systems should pay attention to the judgement of the case of Montgomery versus Lanarkshire in relation to enabling women to make informed choices, informed by robust and comprehensive clinical advice that clearly states the risks associated with each choice. Each woman should have a personalised understanding of the risks that apply to her pregnancy and be able to make decisions about her plan B.

This is reflected in NICE Guideline 190: Intrapartum care for healthy women and babies, which states midwives should support women to consider the range of choices available to them, whilst also discussing any associated risks to enable women to make an informed choice around their preferred place of birth.

To support these discussions, the Maternity Pioneers programme will prepare a toolkit for professionals, designed to support these discussions and ensure that the objective information regarding risk and choice is presented in a way which is helpful to the woman.

Further sources of information

NICE Guideline 190: Intrapartum care for healthy women and babies

7.3.8 Reflecting diversity and supporting vulnerable women

What?
Local Maternity Systems will need to ensure that healthcare professionals understand and respect the cultural and personal circumstances of people from diverse communities.

How?
Local Maternity Systems will need to ensure that workforce training and development, policies and procedures are reviewed. This may involve the Local Maternity System working collaboratively with their Maternity Voices Partnerships and other community groups to co-design new training courses that are co-delivered by experts by experience.

Local Maternity Systems will also need to take into consideration the legal duties to make reasonable adjustments to ensure equality of access to services under the Equality Act 2010, including access to interpreting.

Vulnerable women will need extra support to ensure they receive high quality personalised care and are empowered to make choices. This may require an advocate to work alongside the woman to ensure that her aspirations, needs and wishes are fully expressed during the process of developing or amending the personalised maternity care plan.

For some vulnerable women, there may already be existing services already supporting her and her family. These could include Early Help teams, Children and Families Social Care Teams, Adult Social Care Teams, Community Learning Disability Teams, specialist community health services, secondary care and voluntary sector organisations. In this case the support planning involved in developing the personalised maternity care plan, also needs to reflect the outcomes that the wider team around the individual/ family are working to.

Further sources of information

NHS England Equality and Health Inequalities Hub

8 Community hubs

8.1 What does *Better Births* say?

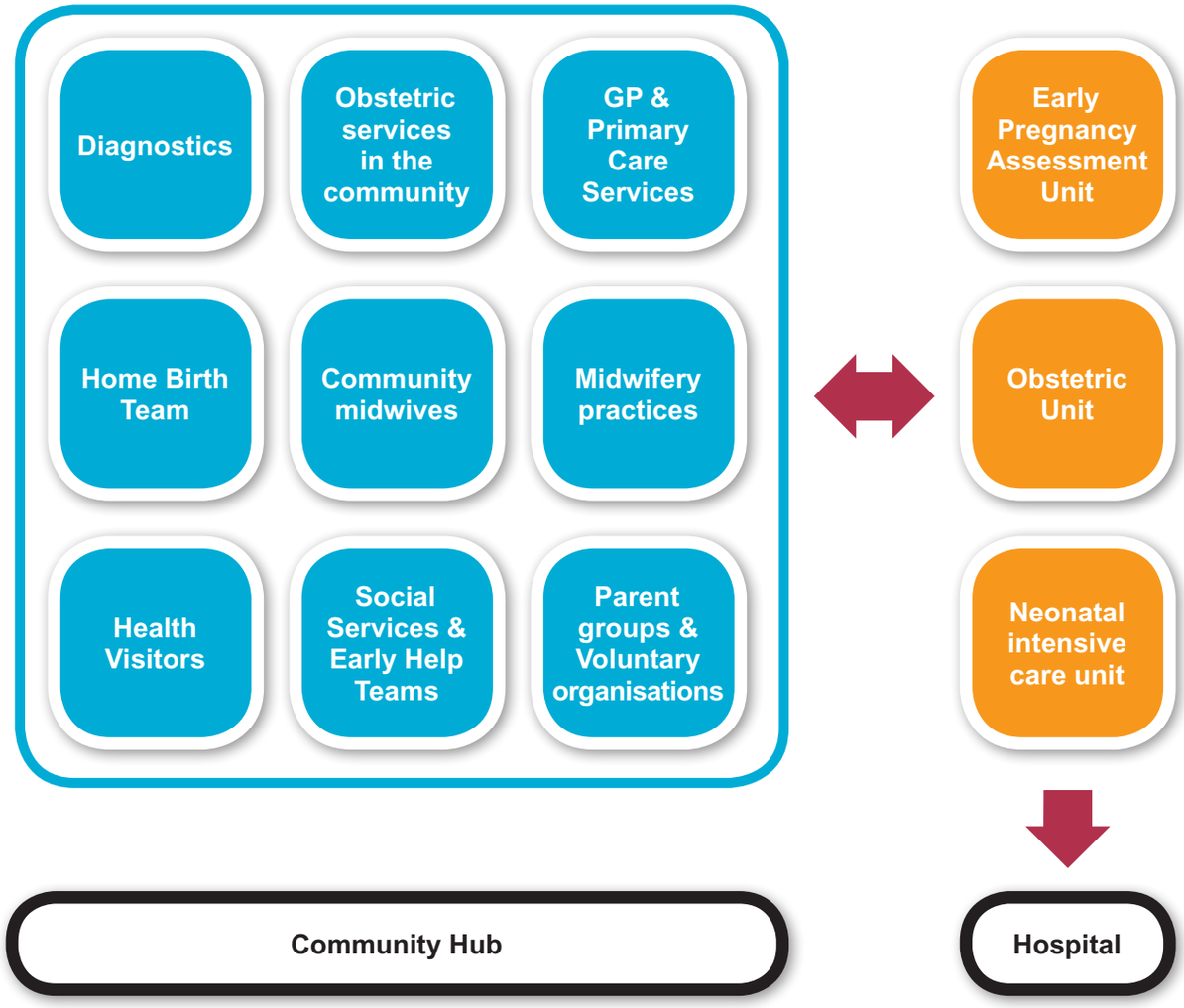
The NHS needs to organise its services around women and families. Community hubs should be identified to help every woman access the services she needs, with obstetric units providing care if she needs more specialised services. Hubs, hospitals and other services will need to work together to wrap the care around each woman.

Community hubs will have two key purposes:

a) *To act as a one stop shop, enabling women to access a range of services under one roof.*

b) *To provide a fast and effective referral service to the right expert if a woman and her baby needs to access more specialised services.*

The Community Hub model



8.2 What is the national programme doing?

Some Early Adopters are moving forward quickly to roll out Community Hubs. Learning will be collected from them and shared with other Local Maternity Systems to consider when developing their own hubs.

8.3 What do Local Maternity Systems need to do and how?

As part of transformation planning, Local Maternity Systems will wish to consider building services around the Community Hub model.

8.3.1 Identifying the scope

What?
Local Maternity Systems will need to identify the range of services to be brought together through the Community Hub based on the needs of the local community, the infrastructure available and the pathways commissioned.

How?
Local Maternity Systems will want to analyse carefully the characteristics of the local population and assess its needs before co-producing the specification with service users. They will want to consider whether including the following services in a Community Hub could improve the quality of care provided:

- Pre-conception care: Information and advice linked to pre-conception and a healthy pregnancy, including outreach programmes.
- Community midwifery care teams providing antenatal and postnatal care: These teams may also provide intrapartum care in a midwifery (birth) unit or at home. The hub may include different teams from different provider organisations, including independent midwifery practices providing NHS services. It may include specialised teams which meet the needs of a specific group of the local population, such as teenage mothers.
- Diagnostic tests: some Community Hubs may be able to offer some diagnostic tests, including scans, in the community. In other cases the hub may have to refer women to the hospital. Decisions on what diagnostic tests a Community Hub is able to offer will need to be based on clinical advice on what is appropriate and ensuring appropriate equipment, space and staff with the right skills and training are in place. It is more likely to be viable where the hub also provides a midwifery (birth) unit and there are sufficient economies of scale.
- Immunisation clinics: vaccinations for influenza and pertussis are recommended in particular for pregnant women, and they may find it easier to access them through community services which they may be visiting regularly.
- Antenatal classes, advice services and group support, run by NHS and voluntary sector organisations.
- Support services and outreach programmes offering support for women with stopping smoking, healthy weight management and drug and alcohol misuse.
- Obstetric services: in some cases there may be sufficient demand for it to be viable to bring obstetricians to the community, rather than to refer women to the hospital. Community Hubs will need clear referral routes into obstetric services, and obstetric services will need clear referral routes to hubs.
- Mental health services: the Community Hub could bring together the range of mental health services women might need, for example, IAPT clinics, joint perinatal mental health community and obstetric clinics, pre-conception counselling for women with complex mental ill health, etc. The hub will need clear referral routes to secondary and tertiary mental health services.
- Specialist clinics: similarly, in some cases it may be viable to arrange clinics in the community for women with pre-existing conditions e.g. HIV, diabetes, epilepsy, where there is sufficient demand.
- Health visitor services may benefit from being joined up with maternity services through the Community Hub so as to help with transition from maternity and neonatal to child health services.
- Postnatal care support clinics, advice or group based sessions linked to promoting the health and wellbeing of the mother, child and family run by NHS and the voluntary sector. Local Maternity Systems will want to consider breastfeeding support in particular.

- Local authority services: in some cases it may be viable for local authorities to offer community drop-in sessions to resolve issues which are not pregnancy-related but which nevertheless impact on and lead to particular anxieties for pregnant women and recent mothers, such as housing. Integration of local authority services will need to be done sensitively to ensure their presence does not affect the likelihood of women accessing NHS services they need or want. In any case, the hub will need good referral routes into local authority services.
- Mother and baby/toddler support groups.
- Access to other parent support groups and voluntary sector organisations that operate locally and nationally.

8.3.2 The model and location

What?
There is not one specific approach to delivering a Community Hub model and each Local Maternity System will need to develop approaches that fit their circumstances and opportunities.

How?
Where the existing infrastructure allows, there is merit in co-locating services. Possible co-locations include:

- Midwifery units.
- Community hospitals.
- Children's centres.
- Primary care centres.
- Community centres.

Some local health economies have identified a need through Sustainability and Transformation Plans to introduce new centres in the community offering a variety of high quality out-of-hospital care services. Where this is happening, Local Maternity Systems will want to give careful consideration to building maternity services into these centres.

It will be important to ensure that any Community Hub model is aligned with the current strategic approach to delivering the children's centre programme, the 0-19 Healthy Child Programme and Early Help.

The Community Hub is not necessarily itself a service, organisation or place; rather it is a coming together of different services in the local community. As such it does not necessarily need to operate from a single building if it can work together effectively across multiple sites. Indeed, in rural areas such an approach may be necessary to properly reflect the needs of a sparser population spread across a larger geographical area. In any case, some services may be rooted in the Community Hub, but be mobile (e.g. home birth teams).

8.3.3 Governance and organisational form

What?
The key is to ensure that a community hub has a clear and agreed operating model. This could involve the creation of a single organisation overseeing a wide range of services but could also feature a range of bodies working together to provide joined up services.

How?
The collaboration agreement should form part of the clinical and operational governance as described in chapter 2 of this document. The governance should include:

- Pathways –all providers should know and understand the care provided by different teams within the Community Hub.
- Shared standards and guidelines, so that clinical teams across the hub work to shared definitions of the care provided at different stages of each pathway.
- Transfer and referral protocols, so that it is clear what happens when a woman and/or her baby need hospital care, care from a different team within the hub (e.g., a community-based mental health service), care from a different NHS provider (e.g., a GP), or support from a local authority service.
- How organisations working through the hub will secure (and, where necessary, pay for) access to facilities owned by another organisation, e.g., accommodation, diagnostic equipment.

As such there will need to be a forum for the different organisations to come together and reach agreement, although this may be provided by the single strategic partnership board of the Local Maternity System in place of having separate boards for each community hub.

If Local Maternity Systems want to establish an organisational form for their Community Hub, it may choose to adopt the following approaches:

a) A formal collaboration akin to a Multispecialty Community Provider (MCP) as envisaged in the Five Year Forward View.

b) A community (primary maternity care) branch of an acute trust functioning in a similar way to a Primary and Acute Care System (PACS) model as envisaged in the *Five Year Forward View.* This may be more suitable in an area where maternity services are provided by a single NHS trust.

Further sources of information

- Integrated primary and acute care systems (PACS) – Describing the care model and business model
- The multispecialty community provider emerging care model and contract framework

9 Continuity of carer

9.1 What does *Better Births* say?

Women told the review team that they see too many midwives and doctors over the course of their pregnancy and the birth, and that they do not always know who they are and what their role is. For some women this leads to confusion and they are not able to build up a rapport with healthcare professionals. Relationship or personal continuity over time has been found to have a positive effect on user experience and outcome.

Just as importantly for safety and clinical effectiveness, if too many health professionals are involved without proper coordination, there may not be effective oversight of the care provided. Evidence shows that continuity models have an impact on improving safety, clinical outcomes, as well as a better experience. In particular, there is evidence that for women who find services hard to access and navigate, they have improved access to care, and there is better coordination of their care between midwifery, specialist and obstetric services. Pre-term births have also been found to be reduced through continuity of the care.

Therefore, the NHS should offer greater continuity of the healthcare professional supporting the woman, her baby and the family. It should involve:

- *a midwife who will normally provide continuity throughout a woman's journey, if that is what she and her partner want;*
- *the midwife will usually work in and be supported by a small team of four to six midwives, one of whom could be a buddy and take responsibility for the woman's care if her midwife is not available;*
- *each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate;*
- *having a midwife the woman knows at the birth. Ideally this will be her own midwife, but if that is not possible, a midwife from the same team of four to six; and*
- *where a woman needs on-going obstetric support, this should be from a single obstetric team and the care should be fully integrated across the midwifery and obstetric services.*

9.2 What is the national programme doing?

NHS England is working with NHS Improvement, Health Education England, the Royal College of Midwives and other partners further to develop guidance on implementing continuity of carer and we will issue further guidance later in 2017 once this work is complete.

The Care Quality Commission has amended the Maternity Experience Survey to include a question on continuity of carer, which Local Maternity Systems will be able to track to gauge how well women's expectations are being met. The national programme is also developing a process measure for possible inclusion in the Maternity Services Dataset.

9.3 What do Local Maternity Systems need to do and how?

What?
Local Maternity Systems should identify a local ambition for implementing continuity of carer models, and plan to deliver it.

How?
This is likely to involve:

- Continuing with existing programmes to ensure each woman has a named midwife who is coordinating her care.
- Working with midwifery staff to identify opportunities for and removing barriers to implementing continuity of carer.
- Working with obstetric staff to provide midwifery teams with an identified obstetrician contact.
- Identifying local clinical leaders to champion continuity of carer.

- Considering approaches for how you might roll it out in your local area. It is likely to be easier to start with a smaller cohort of women before rolling it out more widely. You may want to start with more vulnerable women, which is likely to have the biggest impact on outcomes, and will help to reduce health inequalities.
- Considering the role independent midwifery practices can play in delivering choice and improving capacity in offering women continuity of carer.
- Considering what training might be required to help midwives move to working on a continuity basis.
- Considering the financial case for change, including overall affordability, transition and costs, assumptions about savings and how the transformation will contribute to the STP's financial balance.

It is important to recognise from the outset that it will not be possible for all women to receive continuity of carer. This is because some women will change pathway and, whilst they may start with a community midwife, it may subsequently become apparent that they would benefit from the services of a specialised midwife. Continuity of carer should not get in the way of women being able to access the best clinical care for them in line with their personalised care plan. Similarly continuity of carer should not get in the way of women exercising their right to choose antenatal, intrapartum and/or postnatal care from different providers (e.g., a woman may choose to receive antenatal care in a location close to her work). What is important is that behind the scenes the professionals and systems work together to make the transition seamless.

10 Culture

10.1 What does *Better Births* say?

Front line teams do not operate in a vacuum; leadership is the key determinant of the organisational culture in which front line teams operate. In maternity services, where there are clear leadership roles and channels for both midwifery and obstetric professionals, it is vital that there is collective leadership to create a multi-professional and learning culture.

Midwives and obstetricians, including their management and leadership, must work together as part of a single team focussed on the needs of the women and babies in their care.

It is ultimately the responsibility of the boards of provider organisations to ensure that the culture, systems and processes exist within their organisations to ensure the provision of excellent maternity care and to monitor the quality of the care provided and its associated outcomes on a regular basis. They should identify a board level champion for maternity services.

Provider leadership needs to actively encourage, support and monitor the culture and leadership within their organisations. Teams and individuals must be actively supported and recognised. Organisations could use cultural barometer tools to understand and track their cultural development. A learning culture will also be supported by the routine and systematic measurement and analysis of data on quality and outcomes …

Commissioners should take an interest in the culture of the maternity services that they are commissioning for their communities, as this will be a key determinant of quality and outcomes. They should look at the outputs of any cultural barometer tools used by the organisation, as well as regularly reviewing quality and outcomes data.

10.2 What is the national programme doing?

The national programme is working to identify and share best practice to help Local Maternity Systems improve workforce culture. NHS Improvement's Maternity and Neonatal Health Safety Collaborative will help Local Maternity Systems to understand their culture.

10.3 What do Local Maternity Systems need to do and How?

Better Births identifies areas of culture which may require improvement locally, including:

- Putting women at the centre of care, which means listening to women and acting on what they say.
- Multi-professionalism, which means that staff from different professional groups respect each other, collaborate to put women at the centre of care and learn with and from each other.
- A learning culture, which means that teams make learning and improving services an integral part of their day to day activities. They regularly come together to review and discuss data, investigate mistakes and use them as learning opportunities, they engage enthusiastically in training opportunities and every member of staff feels empowered to speak up and ask questions.

There are enablers elsewhere in this guidance which will help to nurture positive cultures, including the establishment of Local Maternity Systems themselves, enabling clinicians to come together across organisational boundaries. However, to be certain that that the right culture develops, Local Maternity Systems will need to take specific action.

In addition, there is a specific undertaking for Local maternity Systems to embed new arrangements as a result of reform of midwifery supervision.

10.3.1 Leadership

What?
The need for clear leadership, particularly to drive improvements in safety, has been recognised at national level with the appointment of Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE as national maternity safety champions. At regional level, the maternity Clinical Networks are also appointing champions. Local Maternity Systems will need to distribute effective clinical leadership around its constituent parts.

How?
There are clear expectations[10] that:

- Provider boards will have a board level maternity champion, who will ensure an organisational focus on improving outcomes from maternity services.
- Provider trusts will have one obstetrician and one midwife jointly responsible for championing maternity safety in their organisation.
- Local Maternity Systems will identify a lead commissioner for maternity safety to champion the most effective commissioning of maternity services and hold providers to account for improving outcomes. The lead commissioner will sit on the strategic partnership board of the Local Maternity System.

The role of these champions will be to:

- Provide visible organisational leadership and act as a change agent amongst health professionals and the wider maternity team working to deliver safe, personalised maternity care.
- Act as an organisational conduit for sharing learning and best practice arising from national and international research and local investigations or initiatives.
- Build the maternity safety movement in the service locally.

In addition the role of provider board level champions will be to ensure that senior leaders:

- Publish an organisational maternity safety improvement plan.
- Regularly monitor outcomes in their maternity services and against the safety improvement plan, taking action to improve quality where necessary.
- Promote a culture of learning and continuous improvement to maximise quality and outcomes from their services.
- Are visible to and learning from those providing and receiving care.

The role of the clinical champion is:

- Provide clinical leadership for the development and implementation of the safety improvement plan.
- Support the board level and commissioner champions, and ensure links with the local maternity Clinical Network.
- Model multi-professional working.

The role of the commissioner champion is:

- Ensure that the local maternity transformation plan contains a coherent set of activities across the Local Maternity System to improve outcomes.
- Ensure that there are effective and safe maternity pathways across the local maternity system and into specialist services.
- Regularly monitor outcomes across the Local Maternity System and against the local transformation plan, taking action to improve quality where necessary.
- Keep culture across the Local Maternity System under review and initiates action where necessary.

10.3.2 Assessing and monitoring culture

What?
Assessing the culture that exists within a Local Maternity System, organisation or team involves two steps:

- Identifying or gathering information from staff about how they work with each other and how they feel about their work.
- Analysing that information to form conclusions on the drivers of the prevailing culture(s).

10 Safer Maternity Care: Next steps towards the national maternity ambition, https://www.gov.uk/government/publications/safer-maternity-care

How?
There are a number of tools available to help with this task, such as the Culture of Care Barometer developed for NHS England.

Other potential sources of information include staff surveys, more detailed interviews/ focus groups with members of staff, and workshops to explore interactions between members of staff. To maximise the impact the culture ought to be reviewed regularly, ensuring that there is sufficient time between reviews for evidence of change to emerge.

The national Maternal and Neonatal Health Safety Collaborative will play a key role in developing a learning system that provides a methodical way visibly to capture and share positive outcomes or areas of concern, act on them and introduce a cycle of learning to improve; promote effective leadership for safety and develop the conditions required to promote effective team working and communication.

Further sources of information

- Culture of Care Barometer
- Maternity and neonatal health safety collaborative

10.3.3 Taking action

What?
Taking action requires reflecting on the issues and drivers identified through the analysis above and targeting activities at helping with these.

How?
Accordingly, cultural improvement activities will vary substantially between and even within Local Maternity Systems. Examples include:

- If the issue identified is that staff are not routinely personalising care around women, it might be a good idea to undertake some staff workshops with the Maternity Voices Partnership on what the care looks like from service users' perspective.
- If the issue identified is that staff are not working sufficiently across professional boundaries, it might be a good idea to organise more training on a multi-professional basis.
- If the issue identified is that staff report being blamed when things go wrong, it might be a good idea to review procedures for reporting and investigating incidents.

Local Maternity Systems will also need to use the data to identify whether a cultural issue is common to the Local Maternity System or specific to an organisation or team, as the drivers and solutions may be different.

10.3.4 Midwifery Supervision

What?
A new model and framework of midwifery supervision has been developed by the NHS England Supervision Taskforce in light of the removal of statutory supervision of midwives from legislation. It is called Advocating and Educating for Quality Improvement (A-EQUIP) and aims to:

- Facilitate a continuous improvement process that values health professionals by providing restorative clinical supervision.
- Enhance the health and well-being of staff.
- Build personal and professional resilience.
- Contribute to the provision of high quality of care and quality improvement.

The new model builds on Compassion in Practice and is directly aligned with the Five Year Forward View in seeking to develop new ways of working that are person-focused.

The Local Maternity System should ensure that the model is implemented effectively across its area.

How?
To help with this the NHS Standard Contract for 2017/18 contract has been adjusted to include clinical supervision for midwives. It specifies that providers must have in place systems for seeking and recording specialist professional advice and must ensure that every member of staff involved in the provision of the Services receives:

- Proper and sufficient induction, continuous professional and personal development, clinical supervision, training and instruction.
- Full and detailed appraisal (in terms of performance and on-going education and training) using where applicable the Knowledge and Skills Framework or a similar equivalent framework.

- Professional leadership appropriate to the services, each in accordance with good practice and the standards of their relevant professional body, if any, and, in relation to clinical supervision for midwives, any guidance issued by the Department of Health or NHS England.

Further sources of information

A-EQUIP

11 Prevention

11.1 What does *Better Births* say?

Maternity services must recognise the unique role they can play in supporting parents of all backgrounds to maximise their own mental and physical health whilst also equipping parents with the skills, information and confidence to maximise their child's emotional, physical and cognitive development.

11.2 What is the national programme doing?

The national programme is developing an individual prevention pathway, which highlights evidence-based interventions and services. This will help to improve health and wellbeing and reduce health inequalities and risk factors before, during and after pregnancy.

The national programme will also support local authorities in commissioning services that promote a healthy pregnancy and develop professional guidance to support transition from maternity to healthy visiting/ early years.

11.3 What do Local Maternity Systems need to do?

Local Maternity Systems need to implement strategies and services to improve women's health before, during and after pregnancy, give every child the best start in life, and reduce health inequalities.

The Healthy Child Programme (led by health visitors) offers a range of preventative services to all children and families and a targeted offer to those who need additional help and support.

Further sources of information

Healthy Child Programme

11.3.1 Reproductive health, contraception and preconception care

What?
To enable women to be fit for pregnancy, effective interventions must be available to all women of reproductive age to support pregnancy planning, promote contraceptive choices (including in the postpartum period) and promote healthy choices to improve wellbeing and resilience, reduce risk factors and manage long term conditions.

How?
The Local Maternity System will need to consider what services are required in light of the profile of the communities it serves. However, it will undoubtedly need to consider outreach programmes to have the maximum impact. Integrating services with the Community Hub will make it easier to build services around women and their communities. It will also help to ensure that preconception care is part of the postnatal care offer. Embedding opportunistic enquiry about the need for contraception or preconception care across all healthcare settings (e.g. through Making Every Contact Count) will enable more women to access appropriate services.

11.3.2 Promoting positive healthy behaviours and reduction of risk factors

What?
To enable women to be fit during and after pregnancy, early access must be available to universal advice and support for health issues such as smoking, obesity, diabetes, hypertension and mental health issues and advice and support on oral health, postpartum contraception and breastfeeding.

How?
Local Maternity Systems will need to ensure the workforce is able to give advice, offer or refer to interventions, e.g. stop smoking advice and access to nicotine replacement therapy. Support must be readily accessible (ideally co-located), and referral pathways available and understood. The kinds of support required will depend on local needs, but

is likely to include support related to smoking (in line with the *Saving Babies' Lives* care bundle), obesity, diabetes, hypertension and mental health issues. Such services may be part of a universal (i.e. not maternity-specific) offer, such as a general stop smoking service, even if the advice provided needs to take the woman's pregnancy into account.

Delivering such a service will require joined up working between the NHS and local authorities to ensure that support services are available for women to be offered. Integrating services through the Community Hub will simplify pathways and make it easier to women to access services.

11.3.3 Screening programmes

What?
There are six national antenatal and newborn screening programmes with delineated polices, pathways and service specifications.

Antenatal Screening:

- Infectious Diseases in Pregnancy.
- Sickle Cell and Thalassaemia.
- Fetal Anomaly.

Newborn Screening:

- Newborn Hearing.
- Newborn Blood spot.
- Newborn and Infant Physical Examination.

How?
Screening programmes are commissioned in line with NHS England guidance. The Local Maternity System will need to ensure that the screening pathway is effectively aligned with the broader maternity pathway and approach to delivering Community Hubs.

Further sources of information

- Screening programme service specifications
- Guidance for Providers and Commissioners: Who Pays for What? Aspects of the Maternity Pathway Payment for the Screening and Immunisations Programmes

11.3.4 Immunisation

What?
Some vaccinations, in particular for influenza and pertussis, are recommended for pregnant women, but vaccination rates are low. Local Maternity Systems will need to develop strategies for improving rates.

How?
Local maternity systems should make it as easy as possible for women to receive vaccinations. In particular, women may find it easier to access them as a bolt-on to antenatal appointments, rather than through a GP which requires making a separate appointment.

12 Mental health in the perinatal period

12.1 What does *Better Births* say?

The mental wellbeing of women and their families is as important as the physical wellbeing of the women and developing baby – the NHS needs to consider this in an integrated way.

12.2 What is the national programme doing?

The *NHS Five Year Forward View for Mental Health* implementation plan[11] includes the objective that by 2020/21, there will be increased access to specialist perinatal mental health support in all areas in England allowing at least an additional 30,000 women each year to receive evidence based treatment, closer to home, when they need it. A phased, five-year transformation programme, backed by £365m in funding, is underway to build the required capacity and capability.

Meeting the objective will require closing the gap in the large majority (85%) of localities which are estimated to have either a service that does not meet NICE guidelines, or no service at all. This also includes procurement of additional mother and baby units to increase capacity in areas with particular access issues and review of capacity in existing units, which will be undertaken by NHS England.

Progress is already being made with 20 areas receiving funding through wave 1 of the Perinatal Mental Health Community Services Development Fund[12] to expand existing or establish small new specialist community teams, working in partnership with their localities.

Four new, eight-bedded Mother and Baby Units are also being commissioned in areas of the country with particular access issues. Contracts are expected to be awarded in April 2017 with implementation at pace in the coming year.

12.3 What do Local Maternity Systems need to do and how?

What?
Maternity services have a core role to play in the early identification of mental health problems. The NICE quality standard on Antenatal and Postnatal Mental Health highlights a specific quality standard on women being asked about their emotional wellbeing at every ante- and postnatal contact.

They also need to ensure women are referred in a timely way for more specialist support as required. This includes both to local IAPT services and assessment and treatment by secondary and tertiary mental health services.

A range of other, non-statutory services that support women, their babies and families can also be important parts of enabling mental wellbeing, including voluntary and community sector support that may be available through Community Hubs, for example.

In addition, Saving Lives, Improving Mother's Care (2015)[13] has reported that, for staff in maternity services and general practice, awareness of 'red flag' signs, as well as clear pathways of care will help ensure that women get appropriate referral when they need mental health care.

Red flag signs include:

- Recent significant change in mental state or emergence of new symptoms.
- New thoughts or acts of violent self-harm.
- New and persistent expressions of incompetency as a mother or estrangement from the infant.

11 NHS England (2016) *Implementing the Five Year Forward View for Mental Health*
12 https://www.england.nhs.uk/mental-health/perinatal/community-services/
13 MBRRACE (2015) *Saving Lives, Improving Mother's Care*

How?
Achieving improvements across the system clearly requires the involvement of a range of local partners, and clear pathways of care, supported by strategic planning to identify current provision and areas for improvement.

Commissioners will want to ensure that these integrated care pathways are clear to support mental health in pregnancy and postpartum and are working effectively, and that the services they commission are considering integrated physical and mental health at all points to enable women to experience high quality, personalised maternity care without any inequity in access.

Perinatal mental health networks have already been established across England to support strategic joint working and aid service improvement, with a focus on including all key system partners and women with lived experience. Local maternity systems will want to consider how they can engage with these networks, and others, to enable delivery of high quality care.

Further sources of information

NICE quality standard on Antenatal and Postnatal Mental Health

13 Neonatal care

13.1 What does *Better Births* say?

Maternity services cannot be considered in isolation and are inextricably linked to neonatal services, which are key in delivering optimal outcomes for babies.

13.2 What is the national programme doing?

Neonatal services form part of an integrated pathway for high quality maternity, paediatric and family care serving defined regional populations. They are commissioned by NHS England as a specialised service.

Neonatal care services are provided in a variety of settings dependent upon what the baby requires and managed within Operational Delivery Networks. However, the service is challenged by a lack of appropriate capacity, poor nurse and medical staffing levels and uncertainty over the best models of care, particularly in the immediate perinatal period. The case for change in Neonatal Services is based on the need to start neonatal intensive care in the right place to promote survival and minimise morbidity, whilst keeping families as close to home as possible.

The national programme, through the Neonatal Critical Care Clinical Reference Group is carrying out a neonatal care review and will be reporting its findings and recommendations in September 2017.

13.3 What do Local Maternity Systems need to do?

Using the findings and recommendations from the neonatal critical care review, Local Maternity Systems will need to develop and deliver local plans to reduce the variation in neonatal outcomes and provide for stronger models of networked care to ensure that high risk babies receive the best care in the optimal setting to maximise life chances. The local Maternity System needs to ensure that it integrates pathways into its plans that deliver optimal perinatal and neonatal care. In many areas of practice, for example extremely or very preterm birth, the management of fetal growth restriction or fetal anomaly, through well coordinated clinical practice is necessary to ensure optimal outcomes using specific interventions. Good midwifery care in the immediate perinatal period may avoid admission to a neonatal unit and therefore unnecessary separation of mother and baby.

In particular, Local Maternity Systems will need to work with Neonatal Operational Delivery Networks to ensure that there is (as part of shared clinical and operational governance described in chapter 2) a joint policy on care for women where there is an anticipation of the need for neonatal intensive care at and after birth. The system should be orientated to ensure that all women at high risk of extremely preterm labour (23-26 weeks of gestation inclusive) are delivered in a centre with a designated neonatal intensive care unit, unless prior exemption has been sought. Local Maternity Systems need to work with neonatal teams to ensure that there is appropriate capacity to accommodate these women, a clear policy to offer screening to those at high risk of delivery and therefore transfer, and use of antenatal steroid and intrapartum magnesium sulphate as maternally administered medicines to provide for improved outcomes.

14 Postnatal care

14.1 What does *Better Births* say?

Caring for the woman and her baby after birth is equally as important as during pregnancy and birth. Current postnatal services are under-resourced and overlooked …

Postnatal care should be led by the woman's own midwife, who should help her to develop the element of her personalised care plan, and provide care alongside others, including as appropriate maternity support workers, to:

- *Support her to care for herself and her baby including ensuring she knows when to contact her midwife for support and advice.*
- *Perform the new-born examination.*
- *Facilitate minor common medical interventions without separating her from her baby ('transitional care').*
- *Supporting her in feeding her baby in accordance with her personalised care plan.*
- *Involve her partner, family and friends who will play a key part in in supporting her to raise her child.*
- *Signpost her to voluntary sector and other community support.*
- *Keep under review the physical and mental health of the mother and provide rapid referral to more specialised services including when complications or trauma have arisen during labour and mental health services.*
- *Keep under review the health of the baby, including difficulties in feeding and responsiveness that might indicate underlying concerns (such as sepsis and jaundice).*
- *Include a comprehensive handover to the health visitor for the baby and GP or other health professional involved in care prior to pregnancy for the woman's own ongoing health.*

14.2 What is the national programme doing?

NHS England is working with Public Health England and other partners to further develop guidance about how to improve postnatal services and will issue further guidance later in 2017 once this work is complete.

14.3 What should Local Maternity Systems do and how?

What?
In the meantime, Local Maternity Systems should begin to plan to improve postnatal care.

How?
This is likely to involve:

- Bringing together NHS maternity services, health visitors and GPs, mapping the roles currently played by each and identifying opportunities for and barriers to improving postnatal care.
- Working with local service users to identify service user expectations for postnatal care.
- Considering approaches for how the Local Maternity Systems might improve postnatal care. Areas of interest might include breastfeeding, perinatal mental health, stopping smoking and postpartum contraception. It will also be important to consider access to the woman's own midwife in line with chapter 9.
- Considering the role the voluntary and community sector and independent midwifery practices can play in improving quality and capacity in postnatal care.
- Improving transition between maternity services and the health visiting team, in particular by including the handover in the personalised care plan.

Local Maternity Systems should pay particular attention to the provision of bereavement support to women and their families when a baby dies during pregnancy or whilst receiving specialist support through neonatal intensive care units.

Local Maternity Systems will need to consider the following in particular:

- Specialist training available to staff.
- Availability of specialist bereavement midwives.
- Availability of bereavement rooms and facilities to enable women and their families to spend time with their baby.
- Links to funeral directors.
- Links to national charities, local support groups and bereavement counselling services.

Further sources of information

Local Maternity Systems can find useful resources from Sands:

- Sands (2016) Pregnancy Loss and the Death of a Baby: Guidelines for Professionals 4th Edition
- Sands (2016) Audit of bereavement care provision on UK maternity units

15 Workforce transformation

15.1 What does *Better Births* say?

Healthcare professionals should be able to work in an environment of empowered professionalism where their skills are valued and they can see the impact they have on women and their families.

15.2 What is the national programme doing?

Transformation of the workforce is key in initiating the changes required to deliver more personalised and safer care. Health Education England (HEE) is producing a workforce analysis which will form a baseline for future work around supporting local transformation, alongside service redesign which will help define the future shape of the workforce in the context of available supply, and consider the development of professional roles. We will issue further guidance in late 2017 once this work is complete.

To support place-based commissioning, HEE has established **Local Workforce Action Boards** to provide strategic leadership for local workforce transformation strategies to support Sustainability and Transformation Plans. These are either coterminous with an STP footprint or cover two or three STP areas. Local Workforce Action Boards will:

- Create a workforce development plan based on robust commissioner intentions and provider plans.
- Work in partnership with universities, other education providers and research and innovation organisations.
- Establish a joined up approach to workforce planning and transformation with local authorities and health and wellbeing boards.
- Share good practice on workforce solutions.
- Support workforce transformation including the up-skilling of current staff.

NHS Improvement is working on safer staffing improvement resources in eight areas, including maternity, which will be available later in 2017. In the meantime, Local Maternity Systems should refer to National Quality Board guidance and advice on workforce planning is available from local HEE offices, with some offering training. The Centre for Workforce Intelligence's Maternity Care Pathways Tool is a useful resource.

Further sources of information

- HEE workforce planning: Six Steps approach
- Local HEE offices
- The Maternity Care Pathways Tool
- National Quality Board

15.3 What do Local Maternity Systems need to and how?

Local Maternity Systems will need to begin to develop a strategy for maternity workforce transformation, as part of their local maternity transformation plans and in alignment with local workforce transformation strategies.

15.3.1 Identifying workforce requirements

What?
The first step is to for Local Maternity Systems to agree models for the future staffing of local services.

How?
Local Maternity Systems will need to undertake an analysis of the gap between the current capacity and capabilities of staff and the capacity and capabilities required to deliver the vision set out in *Better Births.* This will include consideration in particular of:

- Capabilities required to improve the safety of care.
- Capabilities required to promote personalisation and choice.
- Capabilities to work on a multi-professional basis.
- Configuration and capabilities required to operate on a continuity of carer basis.
- Capabilities required to deliver an integrated pathway with rapid referral to more specialist services (e.g. obstetric, mental health).

Health Education England will provide support and Local Maternity Systems will also be able to consider the forthcoming safer staffing improvement resources from NHS Improvement.

Local Maternity Systems also need to work closely with Health Education England offices and Local Workforce Action Boards as they develop four key products as part of the Sustainability and Transformation Plan:

- A comprehensive baseline of the NHS and care workforce within the STP footprint and an overarching assessment of the key issues that the relevant labour markets(s) present. This will describe the workforce case for change.
- A scenario based, high level workforce strategy that sets out the workforce implications of the STP's ambitions in terms of workforce type, numbers and skills, including leadership development.
- A workforce transformation plan focused on what is needed to deliver the service ambitions set out in the STP.
- An action plan that proposes the necessary investment in workforce required to support STP delivery, identifying sources of funds to enable its implementation.

15.3.2 Leveraging workforce change

What?
Once local workforce requirements have been developed, Local Maternity Systems will need to develop an effective strategy to encourage a local workforce supply to meet local workforce needs.

How?
Local Maternity Systems will need to work collaboratively with Local Workforce Action Boards who are taking action locally to ensure:

- Workforce intelligence is available and updated.
- The future workforce identified has a supply pipeline.
- Workforce development and transformation is enabled.
- Quality is built into every aspect of education and training.
- Leadership and organisational development is embedded across the STP.

Health Education England is developing a new workforce transformation offer in the STAR tool, a menu of products and activities under key domains to support workforce transformation, focussing on supply, upskilling, new roles, new ways of working and leadership across all care settings. The tool is being developed as an online resource for Local Maternity Systems to refer to as they consider their strategic approach to workforce planning and transformation. This guidance will be updated when this is available.

16 Digitally enabled transformation

16.1 What does *Better Births* say?

- *Unbiased information should be made available to all women to help them make their decisions and develop their care plan. This should be through their own digital maternity tool, which enables them to access their own health records and information that is appropriate to them, including the latest evidence and what services are available locally.*
- *To support sharing of data and information between professionals and organisations, use of an electronic maternity record should be rolled out nationally. Providers should ensure that the woman shares and can input the information that is important to her.*

16.2 What is the national programme doing?

NHS Digital is leading the government's national response on how digital technology can contribute to reducing the three gaps identified in *NHS Five Year Forward View*. This is described in *Personalised Health and Care 2020.*

NHS Digital and NHS England are jointly leading the work at a national level to deliver the digital recommendations in *Better Births.*

This involves building a digital tool for use by women in line with the *Better Births* vision and launching a prototype in October 2017.

It also involves developing standards for electronic records covering:

- An initial core maternity dataset at point of care accessible by the multidisciplinary team and the woman.
- Interoperability.

A "discovery phase" is currently underway**.** This means gathering and analysing information and consulting both business and technical stakeholders to determine the best solution before any services are delivered or technology components built. It will run to the end of March 2017 and will result in technical plans being available and the development of a strategic business case by June 2017.

It will also enable NHS Digital to develop guidance to Local Maternity Systems on investing in the right hardware and software and accessing any national support available. Once this is complete, we will update this chapter of this document.

16.3 What do Local Maternity Systems need to do and how?

What?

In the meantime Local Maternity Systems need to undertake a gap analysis between the digital vision set out in *Better Births,* identify opportunities and ensure any key digital developments are put forward for their Local Digital Roadmap. All Local Digital Roadmaps should have a section on Maternity to support *Better Births*, which should be referenced in the local maternity transformation plan.

How?

Local Maternity Systems might find it helpful to work through the following steps:

1. Create a baseline on the application of technology already available or in use. Existing electronic maternity systems can be reviewed by asking the following questions:
   - Are you using these effectively?
   - What are the barriers to adoption of existing tools, e.g. community midwives lacking mobile/remote access, speed of access or other disincentives to adoption and usage?
   - What is the existing ability to generate and submit the Maternity data set?
   - How easy is it to meet existing routine reporting, e.g. birth notifications, registration?

2. Assess the capability and functionality of existing electronic maternity systems. The following questions may help:
    - Are existing systems capable of interoperability or mobile access?
    - What is the user perspective on existing systems, e.g. are they clunky or no longer fit for purpose?
    - What constraints or opportunities exist to improve capability, e.g. contractual obligations, user groups?
    - Where do decisions rest on technological improvements – either to generic trust based systems or maternity specific solutions?
3. Identify measures to improve user experience through access, enhanced usability and personalisation. The following questions may help:
    - Is there any provision in your system for women to directly access their own information, e.g. a portal?
    - What provision is there to host the local maternity service offer, e.g. regional or trust websites?
4. Develop an understanding of opportunities for collaboration and existing or future local partnership models:
    - What non-digital collaboration is present or in development across care-settings in your Local Maternity Systems?
    - What digital collaboration is present, e.g. information flows between GPs, health visitors, maternity unit?
    - Are there any electronic data flows that exist or that can be started?
    - How many systems are involved, i.e. what is the complexity of environment?
5. Ensure the sharing and use of data between partners is lawful and appropriate. Data sharing must be established between legal entities, and the existence of collaboration across a Local Maternity System or within a Community Hub does not in itself provide a lawful basis. It is important to begin consideration of these issues early on in the process. This approach is commonly called Privacy by Design and includes such tools as the Privacy Impact Assessment. The following questions may help:
    - What legal entities are involved, what contracts, agreements and governance need to be put in place?
    - What data is collected? Where and how will it be made available?
    - How will data consistency, accuracy and quality be ensured?
    - What engagement, communications, and choices are required to support patients and enable lawful flows of data?

Further sources of information

Personalised Health and Care 2020: Using data and technology to transform outcomes for patients and citizens, a framework for action

17 Pricing

17.1 What does *Better Births* say?

The payment system for maternity services should be reformed so that it is fair, incentivises efficiency and pays providers appropriately for the services they provide.

17.2 What is the national programme doing?

NHS England and NHS Improvement have a programme of work that is designed to respond to this recommendation. This includes working with Local Maternity Systems that are using the flexibilities within the current payment system to develop and test new models for delivering integrated maternity services to explore potential new payment approaches. NHS England and NHS Improvement will be working with Early Adopters in particular. Where there is good evidence that a new payment approach may have wider application, we will seek to share these as early as possible with the sector for wider implementation.

NHS England and NHS Improvement are also identifying those aspects of the current pathway tariff that will need to change to support new models of care.

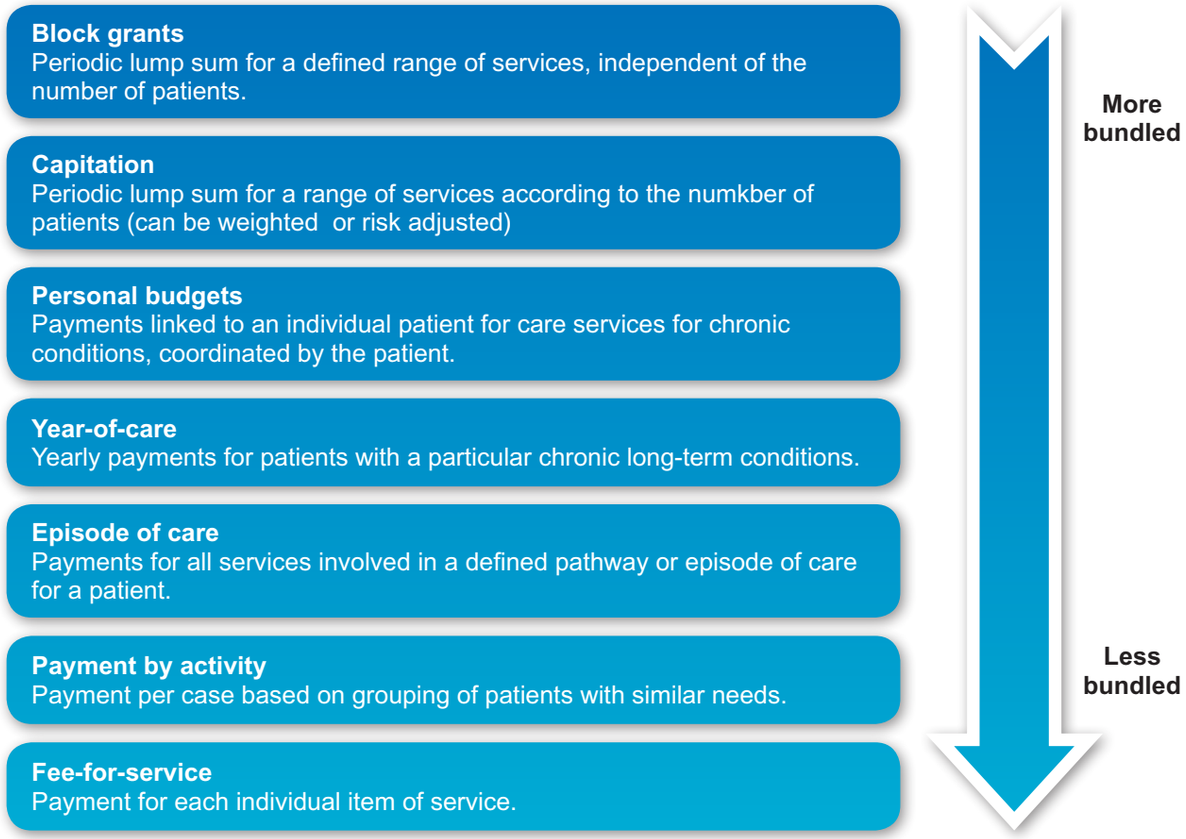
17.3 What do Local Maternity Systems need to do and how?

What?
Given that tariff reform is essentially a national activity, albeit working with Early Adopter Local Maternity Systems to test new approaches, there is no need for action by most Local Maternity Systems. However, a Local Maternity System which is finding the current pathway tariff a barrier to local transformation may want to agree a local variation. A Local Maternity System which is considering this should signal this when agreeing its bespoke support offer.

How?
Local variations are the main mechanism through which commissioners and providers can design alternative payment approaches, and amend currency models, and prices. Local variations must be in the best interest of patients and must be registered on the NHS Improvement portal.

The diagram below gives an overview of the different payment approaches that are commonly in use for healthcare.

Different types of payment approaches



Where nationally mandated prices do not adequately reimburse efficient costs because of particular local circumstances, they can by local agreement, or after determination by NHS Improvement, be changed using the local modification process.

Further sources of information

- The specific services included within and excluded from the Maternity Pathway Payment are set out in Table 1 found in Annex D of 2017/18 and 18/19 National Tariff Payment System
- Guidance on locally determined prices, local variations, and local modifications.
- Further guidance on payment approaches to support new care models

Annex A – Assurance of Local Maternity Systems

The national programme will seek assurance of Local Maternity Systems through regional boards. The regional boards will be asked to make an assessment using key lines of enquiry (KLOEs). The approach will change over time to reflect that there will be an initial Local Maternity System establishment phase, the development of a local plan and an implementation phase.

For the first stage, from April 2017, this will involve the following KLOEs:

a. Has a Local Maternity System been created which is coterminous with the STP footprint and involving all commissioners and providers of maternity services?
b. Have appropriate governance structures been set up for the Local Maternity System? Full governance structures include a board, a named lead of suitable seniority and with adequate capacity, a mechanism for service user co-production, and a project management function.
c. Is the Local Maternity System on course to develop a clear, comprehensive and affordable plan to transform local maternity services?

Assurance of local transformation plans, which will take place in November 2017, will focus on the extent to which plans will deliver what Local Maternity Systems have been asked to deliver in their plans – as set out in section 2.3.2 of this document. The KLOEs will be:

a. Are there clear and credible plans to improving the safety of maternity care so that by 2020/21 all services have made significant progress towards the "halve it" ambition of halving rates of still birth and neonatal death, maternal death and brain injuries during birth by 50% by 2030?
b. Is there a clear and credible plan to ensure that serious incidents in maternity services result in good quality investigations and that those investigations result in effective and sustainable action plans, with relevant wider learning shared through the Local Maternity System and with others?
c. Does the plan take account of participation in the NHS Improvement Maternity and Neonatal Health Safety Collaborative?
d. Are there clear and credible plans to roll out personalised care planning as envisaged in section 7.3.2 of this document?
e. Are there clear and credible plans to improve the choices available so that all women are able to make choices about their maternity care as envisaged in *Better Births*? This means that choices must be available in terms of antenatal care and postnatal care, and of the type and place of birth (homebirth, in a midwifery unit, or in a hospital obstetric unit) even if it means crossing tradition boundaries.
f. Is there a local ambition[14] for how women will receive continuity of the person caring for them during pregnancy, birth and postnatally and are there clear and credible plans for implementing it?
g. Is there a local ambition and clear and credible plans to enable more women to give birth in midwifery settings (at home and in midwifery units)?

In addition, assurance will also consider the following four enablers:

a. To what extent is it based on an understanding of the needs of local women and their families and is it aligned to the local STP? This means it should have been co-produced with service users and staff and have been signed off by the strategic partnership board of the STP.
b. To what extent is there evidence that the Local Maternity System has the capacity and capability to implement it?

14 Evidence will be gathered from early adopters and other leading systems to consider whether national ambitions should be put in place for the continuity of carer and midwifery birth measures during 2017

c. To what extent is the plan clear about how it will be implemented? This means including actions and milestones (with responsible owners), how the plan will be delivered, monitored, assured, and evaluated, and how interdependencies with other work streams of the STP (e.g. Digital Roadmap, workforce) will be managed.

d. To what extent does the plan set out a credible financial case for change, including transition costs, assumptions about savings and how the transformation will contribute to the STP's financial balance? This includes an assessment of the need for additional financial investment the Local Maternity System has identified through its plan and the extent to which the business case is credible.

Further key lines of enquiry will be developed to provide assurance of delivery by Local Maternity Systems. This will include measuring outcomes, based on the CCG Improvement and Assessment Framework (see section 4.2 of this document).

Annex B – Core principles for terms of reference for a Maternity Voices Partnership

The terms of reference for a Maternity Voices Partnership should contain:

Core purpose
The core purpose of any Maternity Voices Partnership is to facilitate co-production in the planning, design, implementation and evaluation of NHS maternity services between services users, commissioners and providers working together as equals.

In addition individual partnerships may want to set themselves outcomes-focused goals to help drive strategy. These could be related to choice and personalisation, improving safety, and/or improving women's experience and reducing inequalities, amongst others. These should be relevant to an assessment of the needs of the local population.

Activities
The activities are means by which the partnership will deliver its core purpose. Examples of what they might include are:

- Gather, synthesise and analyse the needs of diverse local communities to come to shared understanding of how local services can better reflect those needs.
- Reach out to seldom heard groups present within the local population to make sure their voices are heard – this may require bespoke approaches to women with particular characteristics.
- Provide leadership to ensure that the service user voice co-produces both Local Maternity System transformation plans and provider level operational plans.
- Provide advice to inform other forms of health and social care strategic planning, for example the Joint Strategic Needs Assessment, Health and Wellbeing Strategies and Sustainability and Transformation Plans.
- Provide constructive challenge and engage in the decision-making process with emerging plans to ensure they reflect the needs of local women and their families.
- Analyse anonymised complaints.
- Provide constructive feedback on existing services and collaboratively identify areas for improvement – "Walk the Patch" is a tried and tested method of examining existing services, talking to those providing and using the service while doing so.
- Get involved in the monitoring of provider contracts.
- Address specific "hotspots" relating to insight from users such as postnatal care, postnatal primary care checks, bereavement care.

Behaviours
The behaviours are expectations of how members of the partnership should work with each other. They may include:

- Work creatively, respectfully and collaboratively.
- Work together as equals, promoting and valuing participation. Listen to, and seek out, the voices of women, families and carers using maternity services. Enable people from diverse communities to have a voice.
- Use experience data and insight as evidence.
- Understand and work with the interdependency that exists between the experience of staff and positive outcomes for women, families and carers.
- Pursue continuous quality improvement with a particular focus on closing inequality gaps.

Rules for appointing the chair
Each Maternity Voices Partnership should have a chair, which may be managed through job-share or chair team. It is best practice for the chair to be a service user. Local application, nomination and selection processes will need to be determined. The chair must have autonomy and be able to work as a critical friend, so election by the members is best practice. This becomes easier when there is a history of public service in maternity voices forums locally, with succession planning. The chair will have a role in mentoring and supporting service user representatives so that they are able to

develop their leadership skills with a view to taking on greater responsibility. However, the Local Maternity System, commissioner or provider will need to assure themselves that the person elected is a suitable person to take on the role. The following principles may be helpful in this:

- The Chair should be able to demonstrate that they have the skills, knowledge and experience to fulfil the role.
- The Chair must be able to demonstrate an ability to operate in the best interests of the group and the strategic objectives of the Maternity Voices Partnership.
- Have an up to date Disclosure and Barring Service (DBS) check.

Accountability and lines of reporting
Each Maternity Voices Partnership should be linked to a decision-making body, to which it is accountable for the delivery of its objectives (and, where appropriate, for the spending of its budget). This may be the strategic partnership board of the Local Maternity System, or a commissioner or provider board or sub-committee.

The chair should have a clearly defined mechanism for reporting to and influencing the decisions of the board, and best practice is for the Maternity Voices Partnership to be represented by a service user on the partnership board of the Local Maternity System. The chair should produce an annual report which is submitted to the board and published. This could cover how it has achieved its objectives (and in particular how it has influenced changes to services) and what the priorities for the coming year will be.

Decision-making processes
The partnership will need rules on how decisions are to be arrived at. These will need to include whether and how to work through sub-committees for specific tasks.

Practicalities
Each partnership will need to set out how it will operate meetings:

- Frequency.
- Quorum.
- Notice and agenda setting.

Further sources of information

Walk the Patch

Annex C - Clinical Quality Improvement Metrics

- Smoking rate at booking.
- Normal birth rate.
- Caesarean section delivery rate in Robson group 1 women.
- Caesarean section delivery rate in Robson group 2 women.
- Caesarean section delivery rate in Robson group 5 women.
- 3rd and 4th degree tear rate among women delivering vaginally.
- Rate of postpartum haemorrhage of 1500ml or greater.
- Rate of successful vaginal birth after a single previous caesarean section.
- Smoking rate at delivery.
- Proportion of babies born at term with an Apgar score <7 at 5 minutes.
- Proportion of babies born at term admitted to the neonatal intensive care unit.
- Proportion of babies readmitted to hospital at <30 days of age.
- Breastfeeding initiation rate.
- Breastfeeding rate at 6-8 weeks.