Darlington, Tees, Hambleton and Richmondshire and Whitby (DTHRW)

Northumberland, Tyne and Wear and Durham (NTWD)

Local Maternity Systems

Transformation Plan - Supporting Information

August 2018

(Updated to include costings for continuity of carer pilots)

Contents

1. Purpose of this document

This document is intended to provide some of the context and rationale behind the development of the Northumberland, Tyne and Wear and Durham (NTWD) LMS and Darlington, Tees, Hambleton and Richmondshire (DTHRW) LMS Transformation Plans. The LMS in West, North and East Cumbria have developed a separate but complementary plan.

2. Better Births Vision

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.**

Overarching Outcomes

1. Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.

2. Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

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

4. Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.

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

6. Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

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

8. Neonatal care - the Northern Neonatal Network will work closely and collaboratively with the Local Maternity Systems to meet the agreed priority areas. It will also aim to ensure that all babies receive the highest quality neonatal care in an appropriate cot as close to home as possible as their clinical needs require.

9. Prevention – the Local Maternity Systems have agreed seven prevention 'must dos' - reducing smoking and alcohol consumption in pregnancy, increase uptake of flu and pertussis vaccination in pregnancy, improve perinatal mental health, increase breast feeding initiation and continuation, promote healthy weight and embed the philosophy of Making Every Contact Count.

3. Context

'Better Births' (2016) recognised that its vision could only be delivered through transformation that is locally led, with support at national and regional levels. It was recommended that Local Maternity Systems were developed in alignment with Sustainability and Transformation Partnerships.

Sustainability and Transformation Partnership (STP)

Sustainability and Transformation Partnerships (STPs) were established to bring together local health and care organisations to work together in a geographic footprint with the aim of developing a local vision and strategy to address the challenges set out in the Five Year Forward View (5YFV) by 2020-21.

The challenges in the 5YFV were focused on closing the following three gaps:

- the health and well-being gap
- the quality of care gap
- the financial gap

With the publication of the planning guidance for the NHS in England in February 2018, the next stage of development for STPs was set out – the move towards the establishment of Integrated Care Systems (ICS).

North Cumbria and the North East (CNE) STPs / ICS

Initially three STPs were established across North Cumbria and the North East (NCNE):

- Durham, Darlington and Tees including Hambleton, Richmondshire and Whitby (DDTHRW),
- Northumberland, Tyne and Wear including North Durham (NTWD); and
- West, North and East Cumbria (WNEC).

The initial STP plans submitted in October 2016 reflected these STP footprints and coterminous Local Maternity Systems (LMS) were established to deliver the Better Births component of each.

As the three STPs matured it became apparent that clinical interdependencies between them, and the common challenges and priorities across them, meant that made sense to begin work much more closely together. Following the publication of the February 2018 planning guidance it became clear that North Cumbria and the North East should formally aspire to become a single ICS.

North Cumbria and the North East (NCNE) now work together, supported by pan-NCNE work programmes and pooled and co-ordinated transformation resource, as a single, aspiring ICS under a single Senior Officer and governance structure.

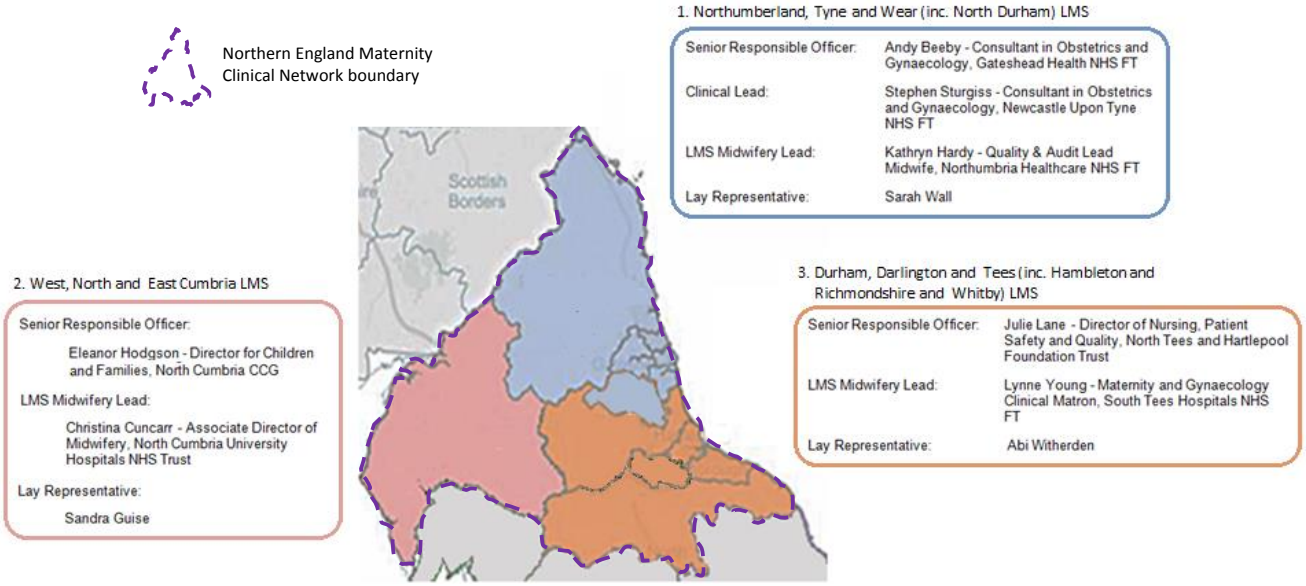
Transformation work is organised on three levels within the aspiring ICS:

- ICS wide
- Sub-regionally - either on the prior STP footprints or on a new Integrated Care Partnership boundary (or which there are four) defined by the reach and collaboration of the services in question
- Place-based locality working

LMS transformation now sits at the sub-regional tier of this new arrangement that is still based on the original geographical footprints (as the best representation of patient flows and collaboration between maternity and obstetric services). This sub-regional approach to LMS delivery is supported at an NCNE level by the Northern England Clinical Network for Maternity Services in order to facilitate sharing of good practice and better support the delivery of equitable services across the whole ICS area). In addition the Clinical Network has provided programme support to the NTWD and DTHRW LMS.

The North Cumbria and North East Local Maternity Systems

This diagram provides an overview of the geography and leadership of the three North Cumbria and North East ICS Local Maternity Systems



NCNE Local Maternity Systems and Northern England Clinical Networks

These Local Maternity Systems are responsible for:

- Developing a local vision for improved maternity services and outcomes which ensures 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 partnerships (STP)
- 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.

The LMS priorities are:

- to implement the national maternity services review "Better Births" on behalf of the NCNE ICA
- to focus on reduction of health inequalities and variations in standards of care
- to encourage collaboration between providers to provide the best care, in the most appropriate setting, closer to the home wherever possible.
- to determine optimal service models based on multiple considerations including quality of care, financial stability and workforce sustainability – as well as support for clinical work via a functioning digital care record (e.g. Great North Care Record)
- to change the focus from hospital-based services to community hubs – building services around the family.

The LMS plans are co-produced with service users and staff to ensure they are fully informed of their choices for care, including seamless and transparent transfer of care to specialist services across the area when required

Darlington, Teesside, Hambleton, Richmondshire and Whitby

5 Clinical Commissioning Groups	1 Mental Health provider
3 Acute providers	7 Councils
2 Ambulance providers	

The current service provision includes: three Consultant-led units in North Tees, South Tees and Darlington; two free-standing Midwifery-led units; and three alongside-Midwifery-led units.

- The implementation of Better Births and the creation of the Local Maternity System (LMS) will be undertaken in alignment with the local STP, incorporating a full understanding of the needs of the local populations.
- The DTHRW LMS footprint has a total population of just over 1.1 million including almost 200,000 women of child-bearing age resulting in over 12,000 annual births.
- These families are served by five Clinical Commissioning Groups (CCGs) commissioning maternity services from three acute provider Trusts.
- The three types of birth location are available across the LMS: three Consultant-led obstetric units, two stand-alone Midwifery-led units and three alongside-Midwifery-led units. The majority of births take place in a hospital environment with approximately 80 homebirths per annum.
- Public Health England developed a 'Maternity Health Needs Data pack' for the LMS which has enabled the LMS to better develop its understanding of the local population and its needs from maternity services
    - Overall birth rates are predicted to increase slightly from 12,227 annual births in 2015, to 12,626 annual births in 2020: The trend based projection rate over 20 years (2015 – 2035) shows variation between localities from a decrease of - 9.1% in Hartlepool to an increase of +10.5% in Middlesbrough (p14).
    - The area contains a lower than UK average number of births to women of black and minority ethnic groups and to non-UK born parents, but a significantly higher teenage pregnancy birth rate (p20-23).
    - Overall flu vaccination rates of pregnant women are significantly higher than the national average; but variation in provision exists (p25).
    - Breastfeeding initiation rates are significantly lower than the national average in all except North Yorkshire (p27).
    - Smoking status at time of delivery (2015/16 data) showed 18 % compared with the national average of 10.6% with the national ambition being below 11% (see p28).

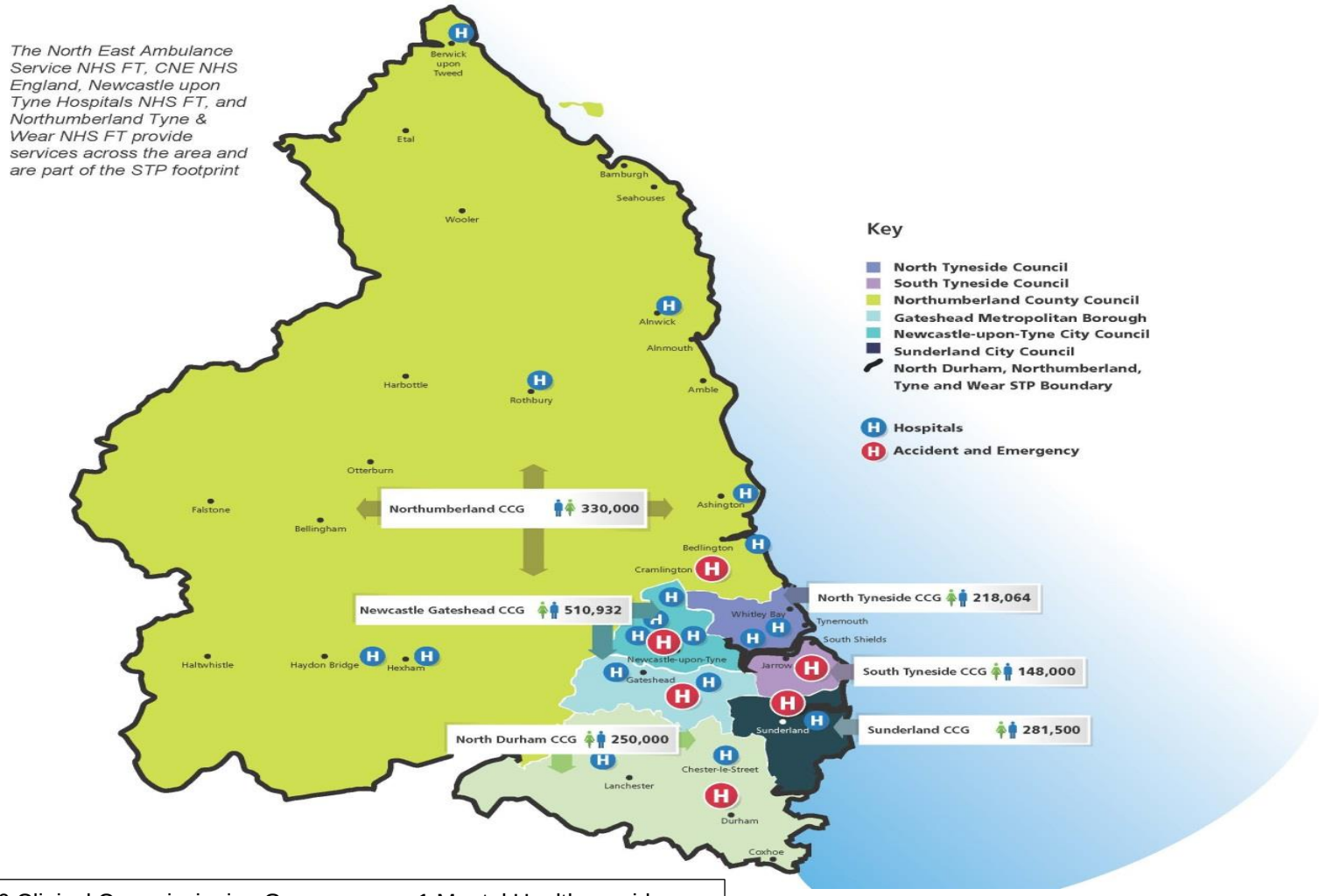
    - The area has good rates of new-born screening and health visitor visits.
- Rates of stillbirth, neonatal death and extended neonatal deaths within the STP as identified by the MBRRACE report (2016) are overall up to 10% lower than the national average but there is variation between acute providers Trusts and CCG areas
- Predicted and current workforce capacity remains of concern amongst both trainee medical staff grades resulting in on use of locum cover and expected shortfalls in the midwifery workforce which follows national predictions
- There is a financial challenge across the STP, any plans produced will be risk assessed to ensure financial capability.

Priorities identified by Better Health Programme

The priorities and previous work of this programme feed into the CNE STP:

- Improve results for patients
- Care of the same standard whenever, and wherever it is provided
- Services have the resources to be sustainable for the next 10-15 years
- Provide services across 7 days a week where necessary
- Make services easier for patients to understand and use
- Improve life expectancy and quality of life

Northumberland, Tyne and Wear and Durham



6 Clinical Commissioning Groups	1 Mental Health provider
5 Acute providers	6 Councils
1 Ambulance provider	

The current service provision includes: six Consultant-led units in Northumbria, Newcastle, Gateshead, Sunderland, Durham and South Tyneside; three free-standing Midwifery-led units; and six alongside-Midwifery-led units

- The implementation of Better Births and the creation of the Local Maternity System (LMS) is being undertaken in alignment with the local STP, incorporating a full understanding of the needs of the local populations.
- The NTWD LMS footprint has a total population of 1.7 million including over 300,000 women of child-bearing age resulting in over 17,500 annual births
- The area covers a mixture of very urban and isolated rural areas.
- These families are served by six CCGs commissioning maternity services from six acute provider Trusts.
- The three types of birth location are available across the LMS: six Consultant-led units (with numbers of births varying from about 6,700 to 1,700 per annum), six alongside Midwifery-led units and three stand-alone Midwifery-led units. The majority of births take place in a hospital environment with approximately 70 homebirths per annum.
- Public Health England developed a ‘Maternity Health Needs Data pack’ for the LMS which has enabled the LMS to better develop its understanding of the local population and its needs from maternity services:

- Overall birth rates are predicted to increase slightly from 17,655 annual births in 2015, to 18,137 annual births in 2020: The trend based projection rate over 20 years (2015 – 2035) shows variation between localities from a decrease of - 7.1% in Northumberland to an increase of + 7.4% in County Durham (p15).
- The area contains a lower than UK average number of births to women of black and minority ethnic groups and to non-UK born parents, but a significantly higher teenage pregnancy birth rate (p20-23)
- Overall flu vaccination rates of pregnant women are significantly higher than the national average; but variation in provision exists (p25).
- Breastfeeding initiation rates are significantly lower than the national average in all areas with an overall rate of just 63.2%. The UK average is 74.3% with variations between areas within the STP of 53%-68.4% (p27).
- Smoking status at time of delivery (2015/16 data) was significantly higher than the national average, 15.3 % compared with the national average of 10.6% with the national ambition being below 11% (p28).

- Rates of stillbirth, neonatal death and extended neonatal deaths within the STP as identified by the most recent MBRRACE report (2016) are overall up to 10% lower than the national average but there is variation between providers and CCG areas
- Predicted and current workforce capacity remains of concern amongst both trainee medical staff grades resultant on use of locum cover and expected shortfalls in the midwifery workforce which follows also national predictions
- There is a financial challenge across the STP, any plans produced will be risk assessed to ensure financial capability.

Maternity Offer

	Northumberland	Tyne and Wear	Durham and Darlington	Teesside	Hambleton Richmond and Whitby	North Cumbria
Obstetric Consultant led	Northumbria Specialist Emergency Care Hospital	Royal Victoria Infirmary Newcastle upon Tyne. Sunderland Royal Hospital. Queen Elizabeth Hospital Gateshead South Tyneside District Hospital.	University Hospital of North Durham. Darlington Memorial Hospital.	University Hospital of North Tees Stockton. James Cook University Hospital Middlesbrough.		Cumberland Infirmary Carlisle. West Cumberland Hospital Whitehaven.
MLU Alongside/Co-located	Northumbria Specialist Emergency Care Hospital	Royal Victoria Infirmary Newcastle upon Tyne. Sunderland Royal Hospital. Queen Elizabeth Hospital Gateshead. South Tyneside District Hospital.	University Hospital of North Durham. Darlington Memorial Hospital.	University Hospital North Tees Stockton. James Cook University Hospital Middlesbrough.		Cumberland Infirmary Carlisle. West Cumberland Hospital Whitehaven.
MLU Stand- alone/ Freestanding	Berwick MLU. Hexham MLU. Hillcrest Alnwick MLU.			University Hospital of Hartlepool.	The Friarage.	Penrith Birthing Centre.
Where units have a co- located MLU provision, the birthing environment may not be physically separated. The birthing environment may be a designated room/s or section of a labour Ward where women follow a midwifery led care pathway						
Home	Each trust offers a home birth service					
Independent Midwifery	Independent Midwifery: Provision for independent midwifery, Yorkshire Storks Midwifery collective and a number of sole traders provide services for the Northern areas. http://www.imuk.org.uk/families/find-a-midwife/					

Care Quality Commission (CQC) Ratings for Hospitals in North East England

The CQC Inspections for the within North East England, have been considered. The table below details the ratings given:

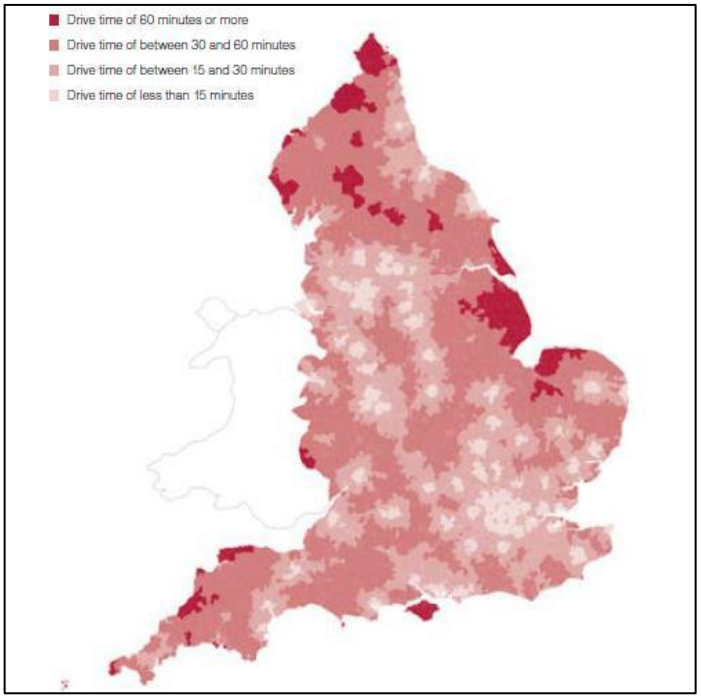
Hospital	Newcastle	Gateshead	Northumbria	Sunderland	South Tyneside	North Tees	County Durham and Darlington	South Tees
CQC Rating Received(Trust)	☆	●	☆	●	●	●	●	●
CQC Rating Received(Maternity Services)	☆	☆	●	●	●	●	●	●

The full inspection reports can be found on the CQC website at the following link http://www.cqc.org.uk/

CQC Ratings Key

☆ Outstanding – the service is performing exceptionally well.
● Good – the service is performing well and meeting our expectations.
● Requires improvement – the service isn't performing as well as it should and we have told the service how it must improve.
● Inadequate – the service is performing badly and we've taken enforcement action against the provider of the service
● No rating/under appeal/rating suspended – there are some services which we can't rate, while some might be under appeal from the provider. Suspended ratings are being reviewed by us and will be published soon.

Average drive times to an Obstetric and Midwifery-led unit, 2013



Across the two LMS some residents of Northumbria and North Cumbria have estimated drive times of 60 minutes are more, reflecting their geographies.

Notes
1 Some women living on the border of Wales or Scotland may have access to a choice of services in those nations.
If so, they may be within shorter drive times than the figure key suggests.

Department of Health (2013) National Audit Office Maternity Services

Service User Surveys

In addition to healthcare led surveys, the Maternity lay representatives for the LMS Boards provide an invaluable role in gathering qualitative and quantitative information by engaging with local women. The two lay representatives have recently asked local mums about their experiences of personalised care planning. To date two data sets are available, one for DTHRW and one for NTWD, each with 100 respondents:

DHTRW 100 respondents from the South Tees area who delivered predominantly at James Cook and North Tees recruited via a Facebook breastfeeding group:
https://www.surveymonkey.com/results/SM-H3YSL2K9L/

NTWD 100 responses from further north recruited via several different Facebook groups:
https://www.surveymonkey.com/results/SM-CZQTPNJ9L/

The questionnaire was short, taking less than 3 minutes to complete and focused on themes from the Implementing Better Births Resource Pack explanation of what a personalised care plan should do. The main questions include:

- Whether mums knew they should have a PCP (60-70% did) and whether they think they had one (20-30% did not).
- What sort of setting in which to deliver (at least a third did not have choice).
- Feelings of empowerment in making their choices.
- Where antenatal and postnatal checks occurred (well over half had no choice).
- Pain relief in labour as stated in the Implementing Better Births pack (around 20% did not get information and choice).
- Whether the planning worked to deliver a maternity experience that was what each woman was expecting. The lay representative wanted to incorporate the importance of alternative options ('Plan B') in asking this question as it is highlighted in the Implementing Better Births pack. (Where a plan was made 20-21% found it did not work - either a situation arose for which they had not planned or their choices were ignored).

3. Health Needs Assessment

In 2017 Public Health England provided a "Maternity Health Needs Data Pack" for each LMS across the country to enable a better understanding of their local population and its needs from maternity services. A small selection of some of the key data that has informed the LMS plans is included below. This is supplemented by data collected across the Maternity Clinical Network through its Maternity Dashboard and submissions to Each Baby Counts and Saving Babies Lives Care Bundle.

Population

DTHRW

Total population, females aged 15 – 44 and number of births

2017/18 CCG boundaries	Total Registered Population (2017)	Total females aged 15-44, registered population (2017)
England	58,437,363	11,525,729
[Durham,]Darlington, Teesside, Hambleton, Richmondshire and Whitby	1,134,796	199,687
NHS Darlington CCG	107,888	19,433
NHS Durham Dales, Easington and Sedgefield CCG	291,043	49,792
NHS Hartlepool and Stockton CCG	296,498	54,638
NHS South Tees CCG	295,548	54,046
NHS Hambleton, Richmondshire and Whitby CCG	143,819	21,778

Source data: NHS Digital, 2017 and ONS births, 2015. Link: https://digital.nhs.uk/catalogue/PUB24180 and https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths (LMS Service Packs, PHE 2017)

NTWD

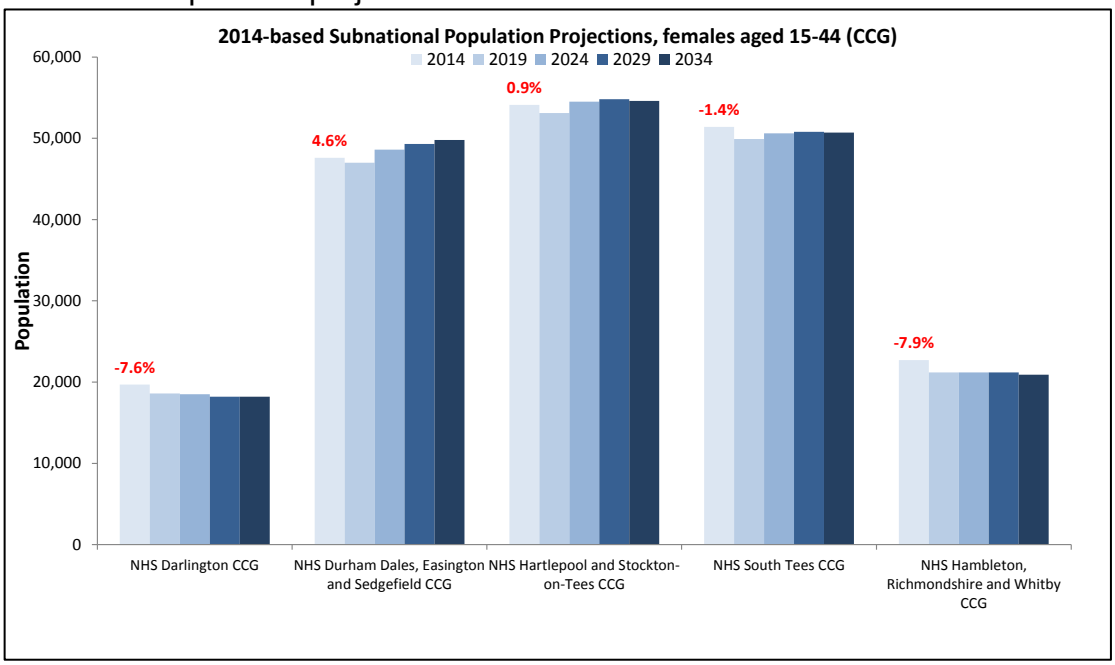
Total population, females aged 15 – 44 and number of births

2017/18 CCG boundaries	Total Registered Population (2017)	Total females aged 15-44, registered population (2017)
England	58,437,363	11,525,729
Northumberland, Tyne and Wear and [North] Durham	1,759,803	333,276
NHS North Durham CCG	256,342	50,201
NHS Northumberland CCG	323,852	51,367
NHS South Tyneside CCG	156,612	27,661
NHS Sunderland CCG	284,161	52,089
NHS Newcastle Gateshead CCG	520,427	112,011
NHS North Tyneside CCG	218,409	39,947

Source data: NHS Digital, 2017 and ONS births, 2015 Link: https://digital.nhs.uk/catalogue/PUB24180 and https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths (LMS Service Packs, PHE 2017

Population projections

DTHRW - Population projections – Females 15-44

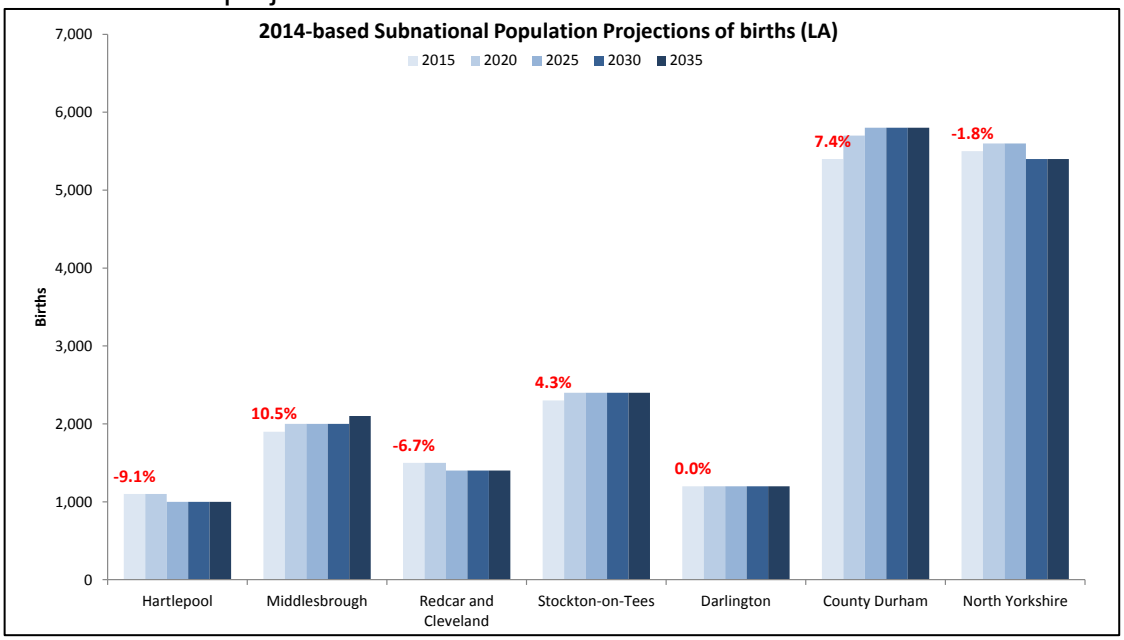


Values in red show increase or decrease in population from 2014 to 2034

Source data: 2014-based Subnational population projections, ONS Link:https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections (LMS Service Packs, PHE 2017)

Overall birth rates are predicted to increase slightly from 12,227 annual births in 2015, to 12,626 annual births in 2020: The trend based projection rate over 20 years (2015 – 2035) shows variation between localities from a decrease of 9.1% in Hartlepool to an increase of 10.5% in Middlesbrough.

DTHRW - Birth projections



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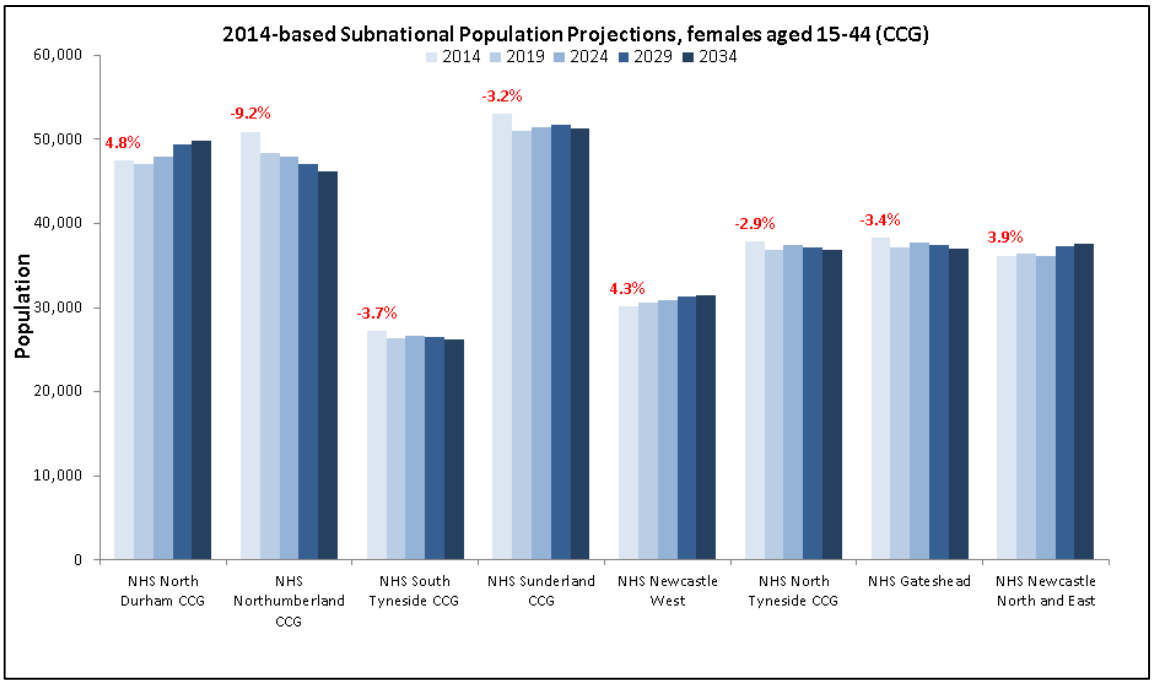
NTWD - Population projections – Females 15-44



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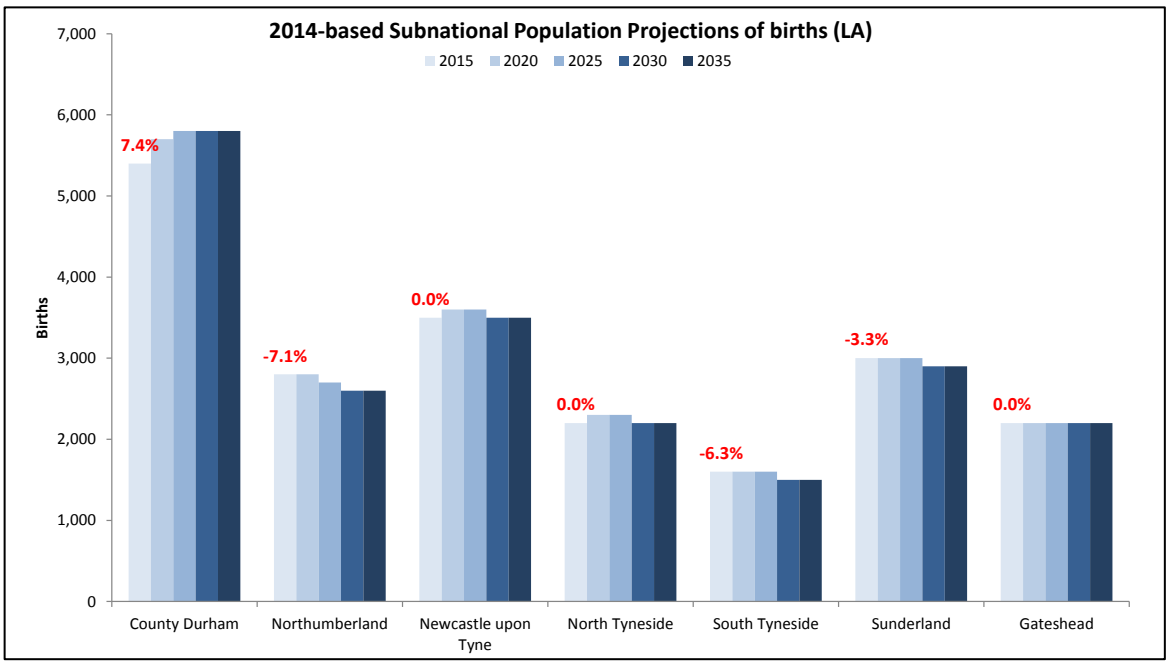
NTWD - Birth projections



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Pregnancy and Birth Key Indicators

Compared with benchmark Better | Similar | Worse | Not compared

Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2016/17	23.3*	8.9	2.5	7.2	7.5	3.1	22.7	24.1	7.3	5.3	3.2	6.8	9.9	6.4
General fertility rate	2016	62.5	58.6	56.5	60.6	60.5	62.2	69.0	50.1	61.1	57.1	61.9	63.1	63.2	57.4
Under 18 conceptions	2016	18.8	24.6	21.6	24.1	20.6	34.9	36.5	20.8	15.4	21.0	31.6	24.0	27.7	31.9
Under 18s conceptions leading to abortion (%)	2016	51.8	41.6	37.0	36.4	55.4	32.8	34.4	39.1	43.8	38.1	35.7	44.8	54.4	48.1
Teenage mothers	2016/17	0.8	1.4	1.5	1.5	1.3	2.0	1.8	1.1	0.9	1.3	2.0	1.3	1.5	1.6
Smoking status at time of delivery (current method)	2016/17	10.7	16.1	16.7	16.2	14.5	15.3	20.3	14.5	12.2	12.9	20.3	20.8	15.3	17.2
Caesarean section %	2016/17	27.1*	25.8	26.0	26.0	24.0	25.9	23.4	26.7	29.9	30.7	22.3	23.3	25.7	22.8
Multiple births	2015	16.0	15.3	17.4	9.9	17.4	14.0	13.1	17.4	16.6	12.8	7.7	14.7	16.0	16.5
Low birth weight of term babies	2016	2.79	2.97	3.02	3.43	2.59	3.35	4.68	3.01	2.78	2.23	2.54	2.70	2.64	3.17
Low birth weight of all babies	2016	7.3	7.4	8.0	10.7	7.5	8.5	9.2	6.1	6.2	5.1	7.2	7.0	8.1	7.6
Very low birth weight of all babies	2016	1.22	0.98	1.21	1.39	0.94	1.34	1.11	0.46	0.59	0.62	1.26	1.01	1.26	1.08
Stillbirth rate	2014 - 16	4.5	3.9	3.4	4.2	4.0	4.7	4.1	3.6	2.8	4.4	4.9	3.4	5.1	3.5
Admissions of babies under 14 days	2016/17	71.0*	73.5	105.6	141.1	58.3	82.7	91.6	76.6	48.4	43.1	70.2	63.3	77.6	32.5
Breastfeeding initiation	2016/17	74.5	59.0	56.0	*	75.6	37.9	47.9	69.4	65.4	65.6	49.9	55.6	48.7	56.6
Breastfeeding prevalence at 6-8 weeks after birth - current method	2016/17	44.4*	31.4	27.9	34.3	36.0	*	25.9	47.1	37.9	35.5	24.9	25.1	*	25.8

Source: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/data#page/0/gid/1938132993/pat/6/par/E12000001/ati/102/are/E06000047

The table above provides an overview of pregnancy and birth indicators across the two LMS in the North East. There are higher than average numbers of teenage mothers, mothers smoking at time of delivery as well as lower breastfeeding initiation rates.

Pregnancy and Birth Trends

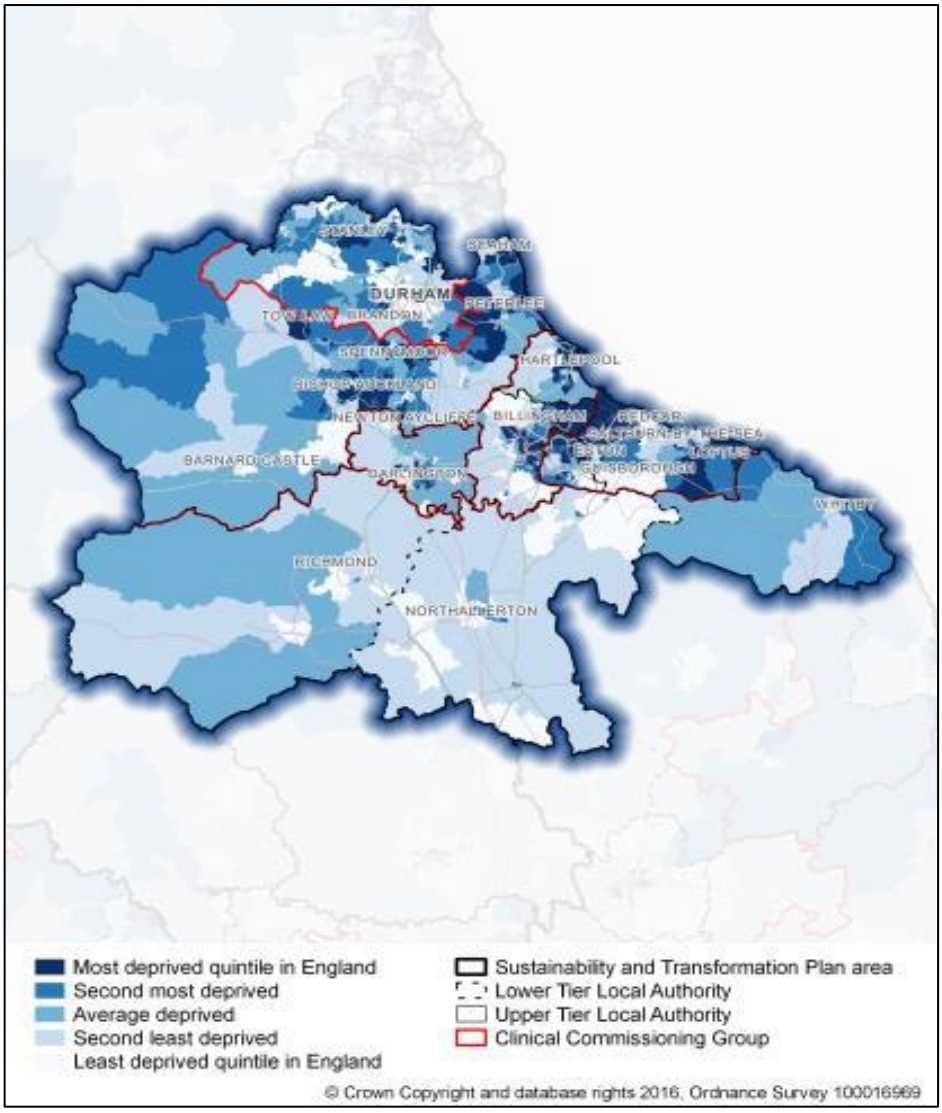
Compared with benchmark Better | Similar | Worse | Not compared

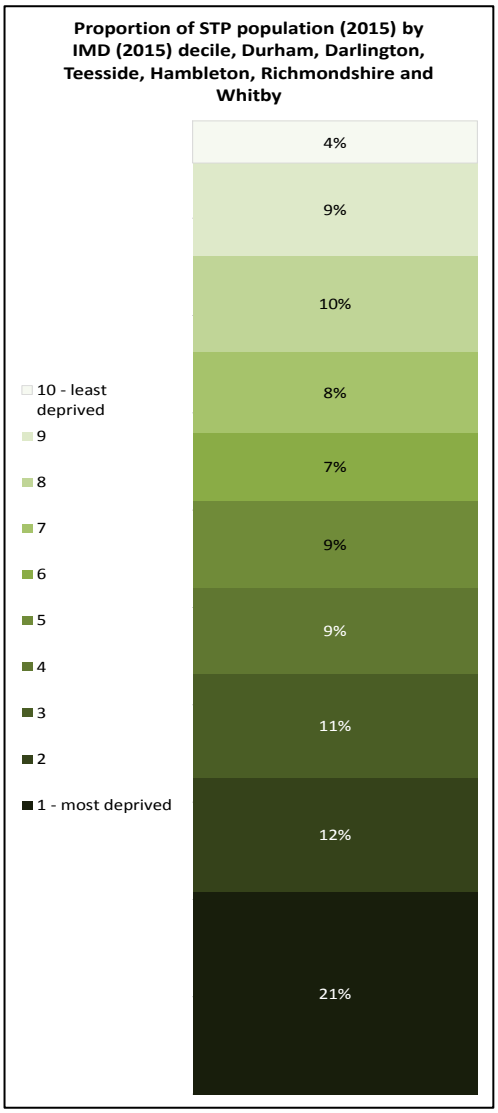
Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2016/17	23.3*	8.9	2.5	7.2	7.5	3.1	22.7	24.1	7.3	5.3	3.2	6.8	9.9	6.4
General fertility rate	2016	62.5	58.6	56.5	60.6	60.5	62.2	69.0	50.1	61.1	57.1	61.9	63.1	63.2	57.4
Under 18 conceptions	2016	18.8	24.6	21.6	24.1	20.6	34.9	36.5	20.8	15.4	21.0	31.6	24.0	27.7	31.9
Under 18s conceptions leading to abortion (%)	2016	51.8	41.6	37.0	36.4	55.4	32.8	34.4	39.1	43.8	38.1	35.7	44.8	54.4	48.1
Teenage mothers	2016/17	0.8	1.4	1.5	1.5	1.3	2.0	1.8	1.1	0.9	1.3	2.0	1.3	1.5	1.6
Smoking status at time of delivery (current method)	2016/17	10.7	16.1	16.7	16.2	14.5	15.3	20.3	14.5	12.2	12.9	20.3	20.8	15.3	17.2
Caesarean section %	2016/17	27.1*	25.8	26.0	26.0	24.0	25.9	23.4	26.7	29.9	30.7	22.3	23.3	25.7	22.8
Multiple births	2015	16.0	15.3	17.4	9.9	17.4	14.0	13.1	17.4	16.6	12.8	7.7	14.7	16.0	16.5
Low birth weight of term babies	2016	2.79	2.97	3.02	3.43	2.59	3.35	4.68	3.01	2.78	2.23	2.54	2.70	2.64	3.17
Low birth weight of all babies	2016	7.3	7.4	8.0	10.7	7.5	8.5	9.2	6.1	6.2	5.1	7.2	7.0	8.1	7.6
Very low birth weight of all babies	2016	1.22	0.98	1.21	1.39	0.94	1.34	1.11	0.46	0.59	0.62	1.26	1.01	1.26	1.08
Stillbirth rate	2014 - 16	4.5	3.9	3.4	4.2	4.0	4.7	4.1	3.6	2.8	4.4	4.9	3.4	5.1	3.5
Admissions of babies under 14 days	2016/17	71.0*	73.5	105.6	141.1	58.3	82.7	91.6	76.6	48.4	43.1	70.2	63.3	77.6	32.5
Breastfeeding initiation	2016/17	74.5	59.0	56.0	*	75.6	37.9	47.9	69.4	65.4	65.6	49.9	55.6	48.7	56.6
Breastfeeding prevalence at 6-8 weeks after birth - current method	2016/17	44.4*	31.4	27.9	34.3	36.0	*	25.9	47.1	37.9	35.5	24.9	25.1	*	25.8

Source: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/data#page/0/gid/1938132993/pat/6/par/E12000001/ati/102/are/E06000047

This table shows trends in the pregnancy and birth indicators. There average numbers of teenage mothers is in the main decreasing or staying at the same rate, mothers smoking at time of delivery is decreasing (getting better) in all but one of the CCGs, where it is staying as at a similar level. However, breastfeeding initiation is decreasing (getting worse) in 4 CCGs and increasing (getting better) in 4 CCGs.

Deprivation DTHRW -



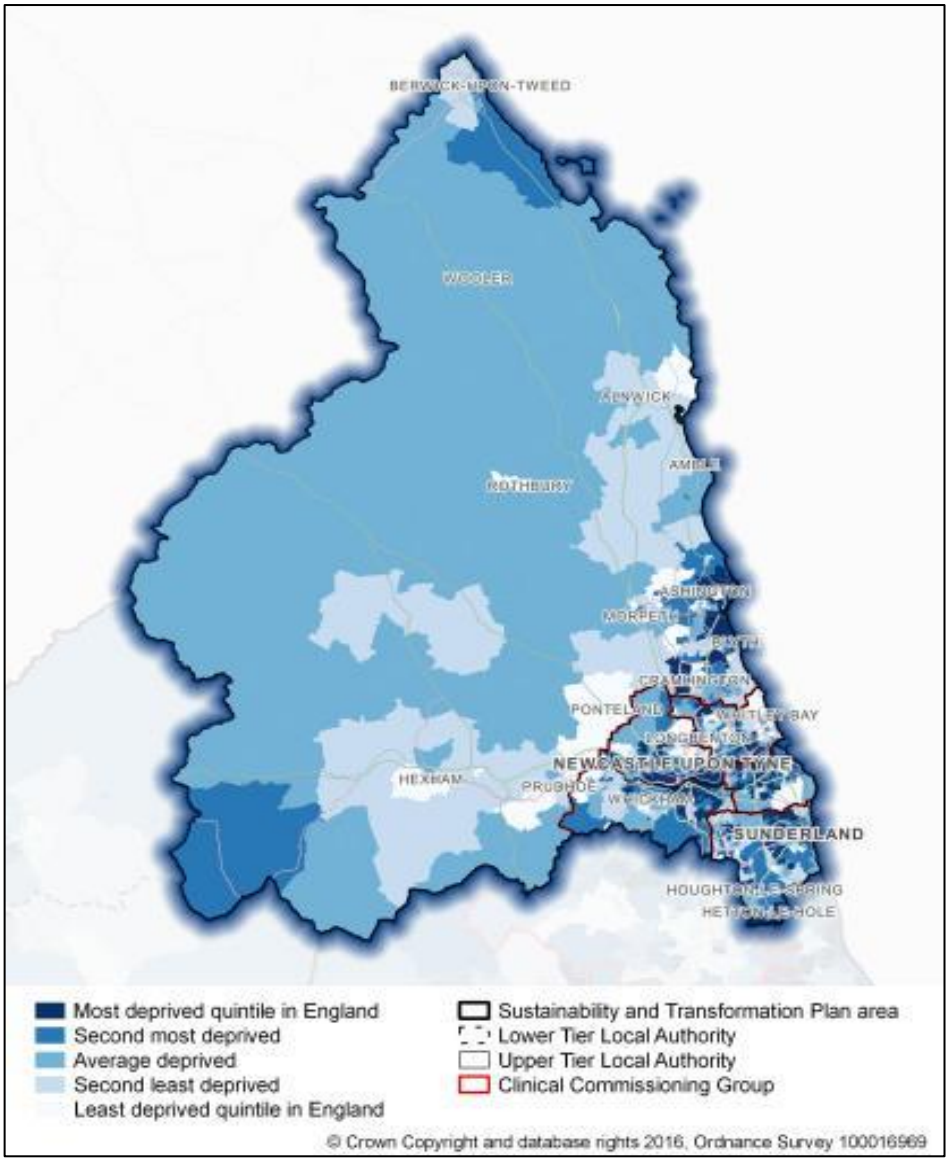


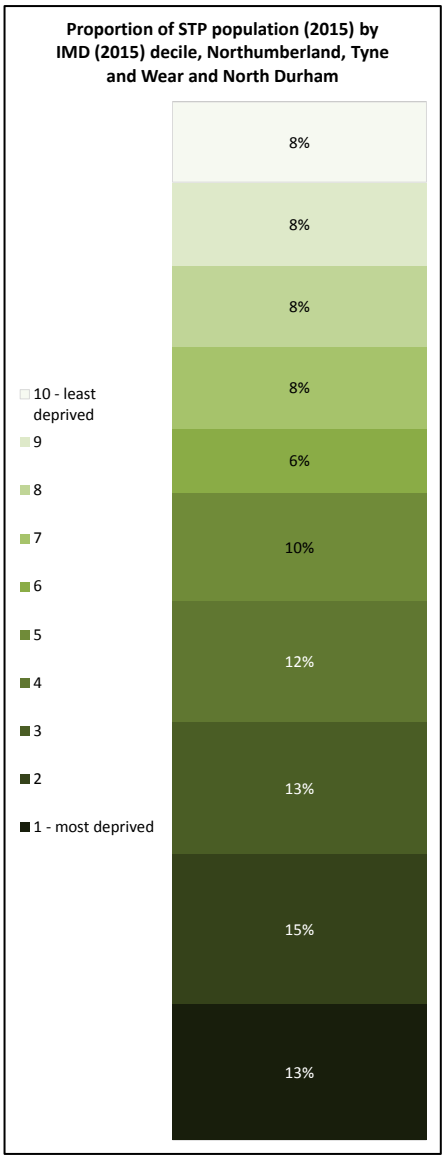
Source data: IMD 2015, DCLG Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015 (LMS Service Packs, PHE 2017)

*"**Rationale** – "Deprivation covers a broad range of issues and refers to unmet needs, caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to measure a broader concept of multiple deprivation, made up of several distinct dimensions, or domains, of deprivation."*

The LMS includes a number of localities which are classed as the most deprived quintile in England. 21% of the population is in the most deprived decile and 4% in the least deprived decile.

Deprivation NTWD





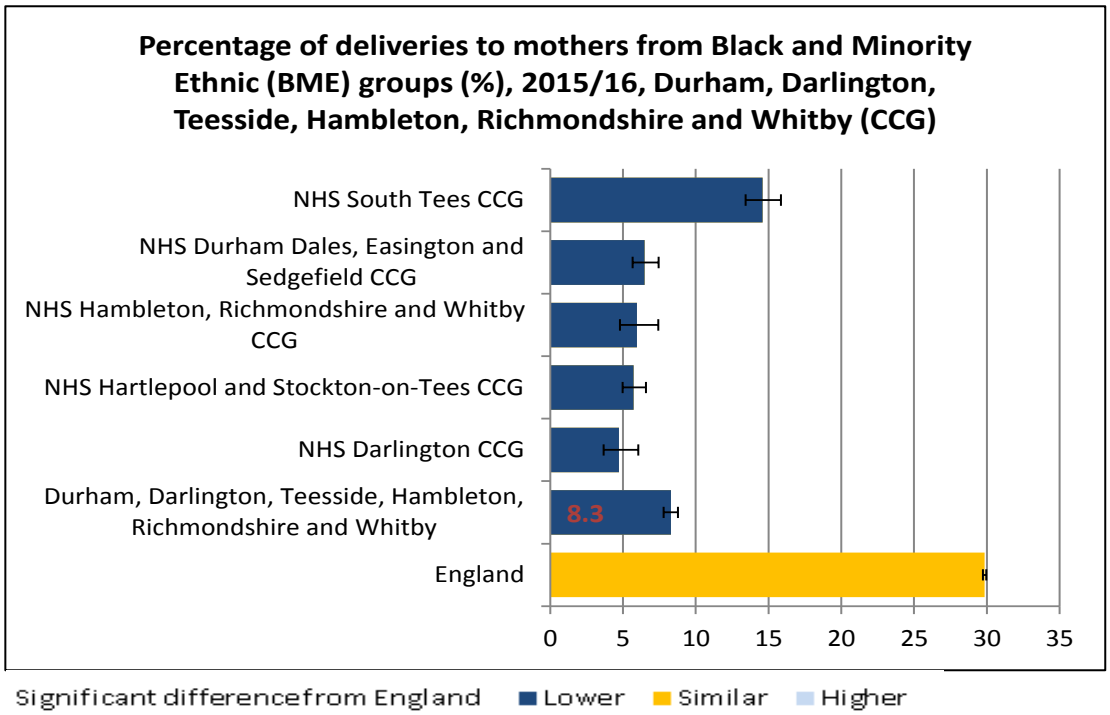
Source data: IMD 2015, DCLG Link: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015 (LMS Service Packs, PHE 2017)

*"**Rationale** – Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to measure a broader concept of multiple deprivation, made up of several distinct dimensions, or domains, of deprivation."*

The LMS includes a small number of localities which are classed as the most deprived quintile in England. 13% of the population is in the most deprived decile and 8% in the least deprived decile.

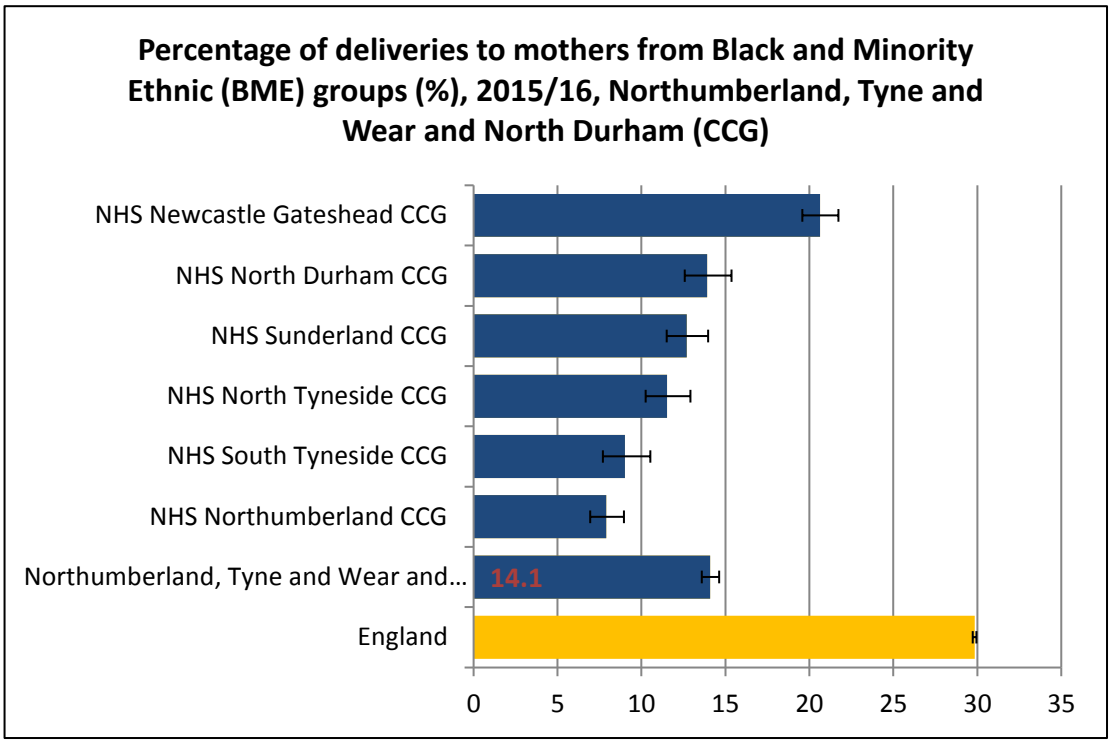
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups

DTHRW



The percentage number of deliveries to mothers from black and minority ethnic (BME) groups is lower particularly in DTHRW in comparison to England at 30%. DTHRW is currently at 8.3% and NTWD at 14.1%.

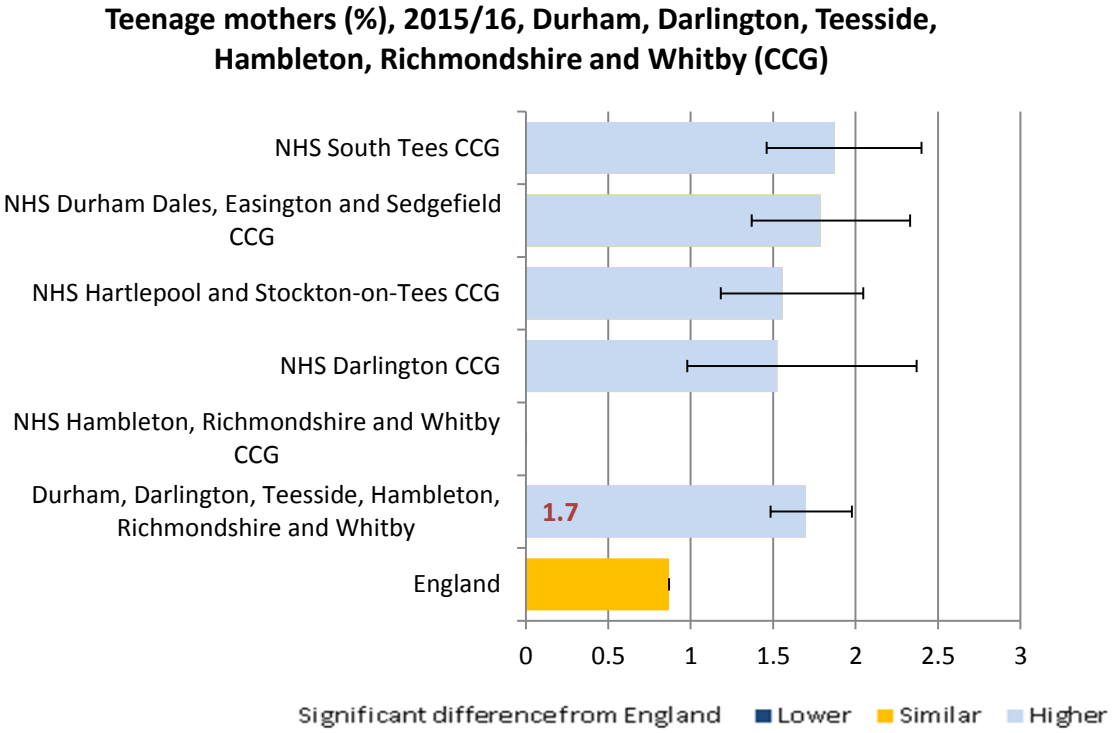
NTWD



Source data: Fingertips – Pregnancy and birth profile, 2015/16 Link: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy *(LMS Service Packs, PHE 2017)*

Percentage of delivery episodes where the mother is aged under 18

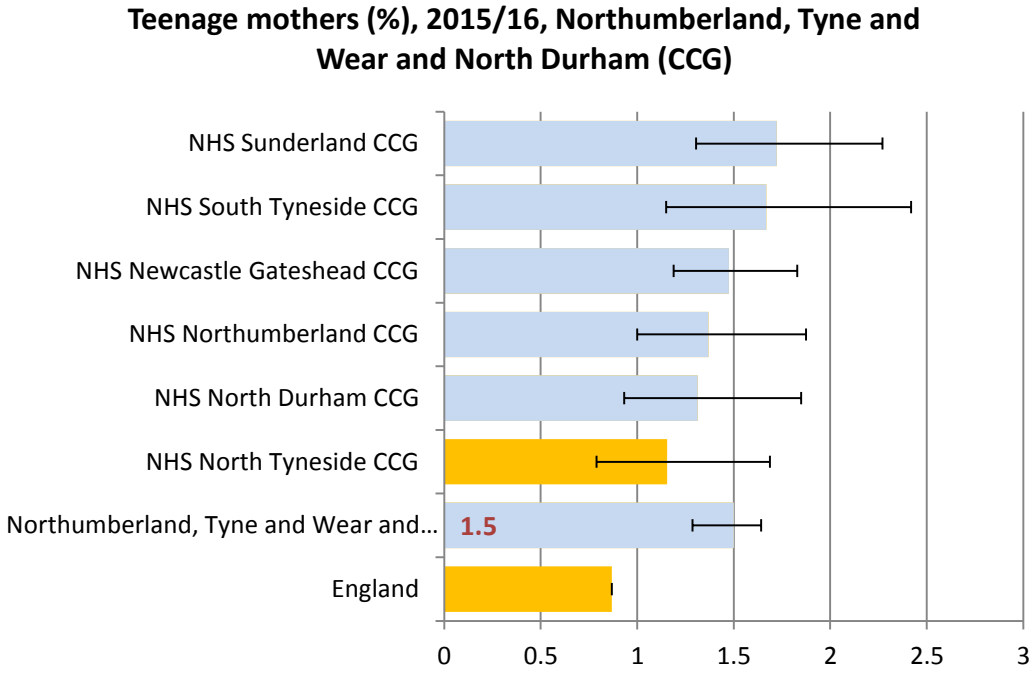
DTHRW



*"**Rationale** – Teenage pregnancy is associated with poorer outcomes for both young parents and their children."*

The percentage of teenage mothers in the North region is somewhat higher than those in England. Both NTWD and DTHRW have a similar position on average of 1.6%. The highest percentage of teenage mothers delivered in NHS South Tees CCG, NHS Durham Dales, Easington and Sedgefield CCG and Sunderland CCG.

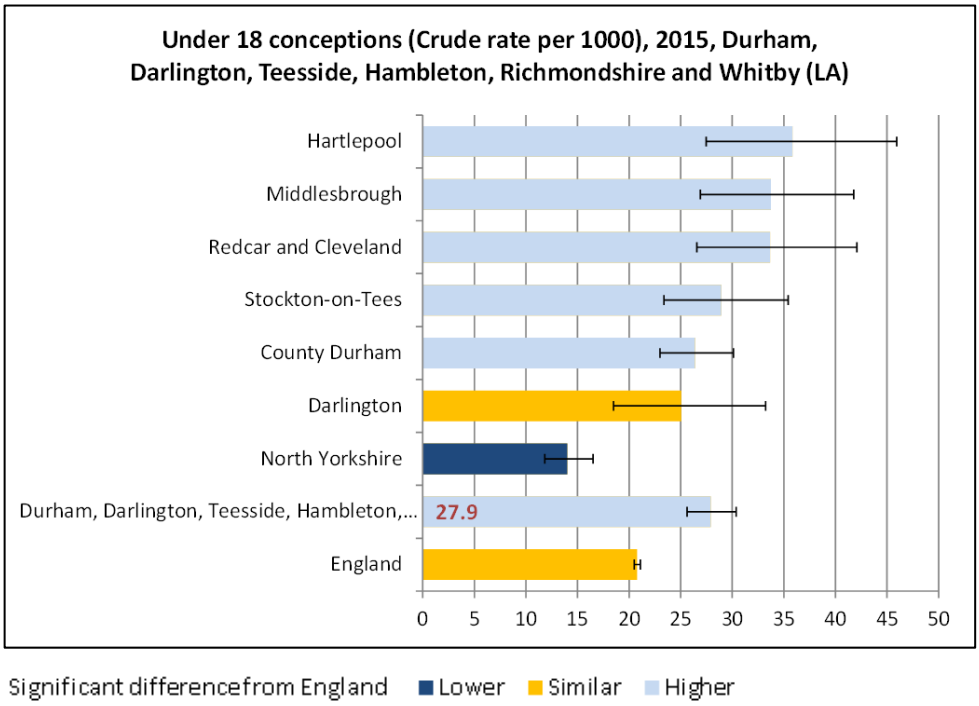
NTWD



Source data: Fingertips – Pregnancy and birth profile, 2015/16
Link: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy (LMS Service Packs, PHE 2017)

Under 18 conceptions

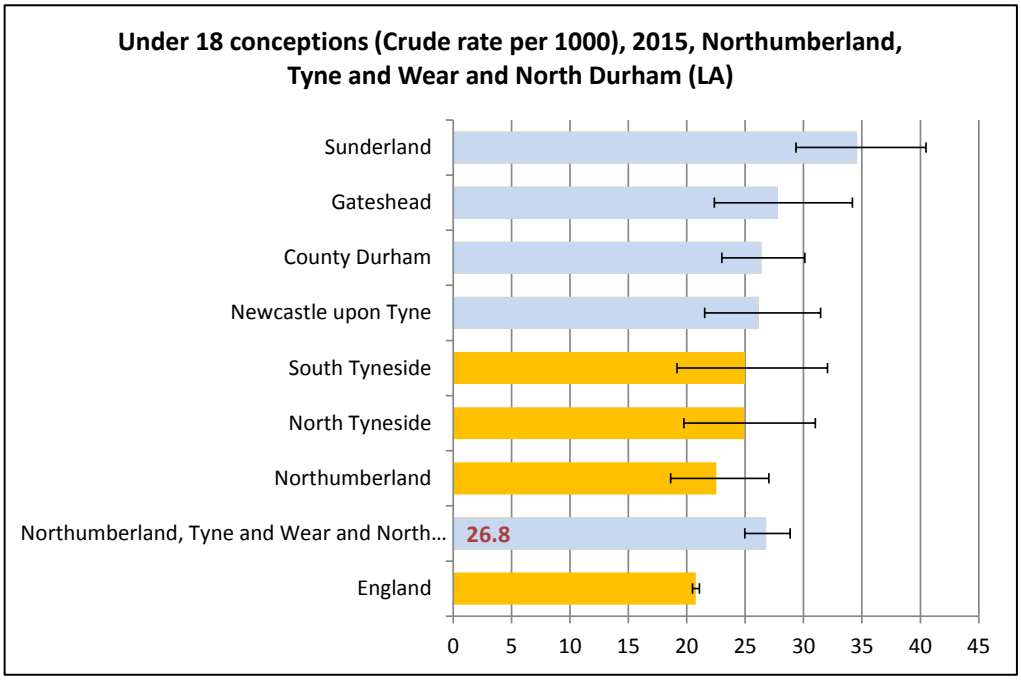
DTHRW



*"**Rationale** – Teenage pregnancy is associated with poorer outcomes for both young parents and their children. This indicator can show local variation. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems."*

In both NTWD and DTHRW under 18 conceptions in Northern England is somewhat higher than England. NHS Hartlepool CCG and Sunderland CCG are significantly higher than England.

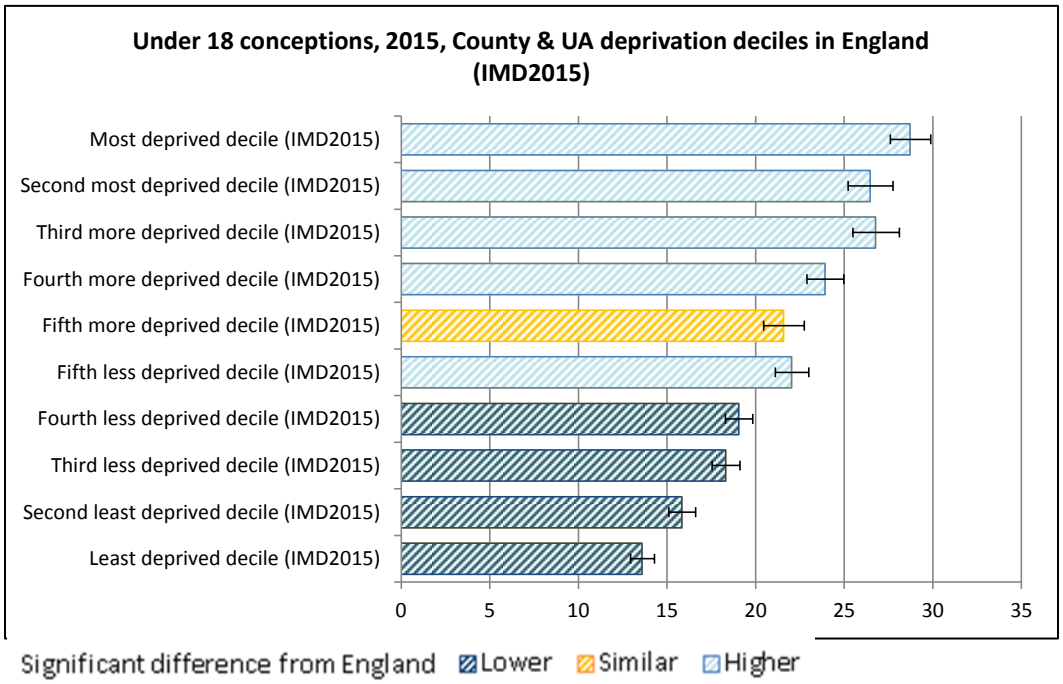
NTWD



Source data: Fingertips – Pregnancy and birth profile, 2015
Link: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy (LMS Service Packs, PHE 2017)

Under 18 conceptions by deprivation decile

DTHRW

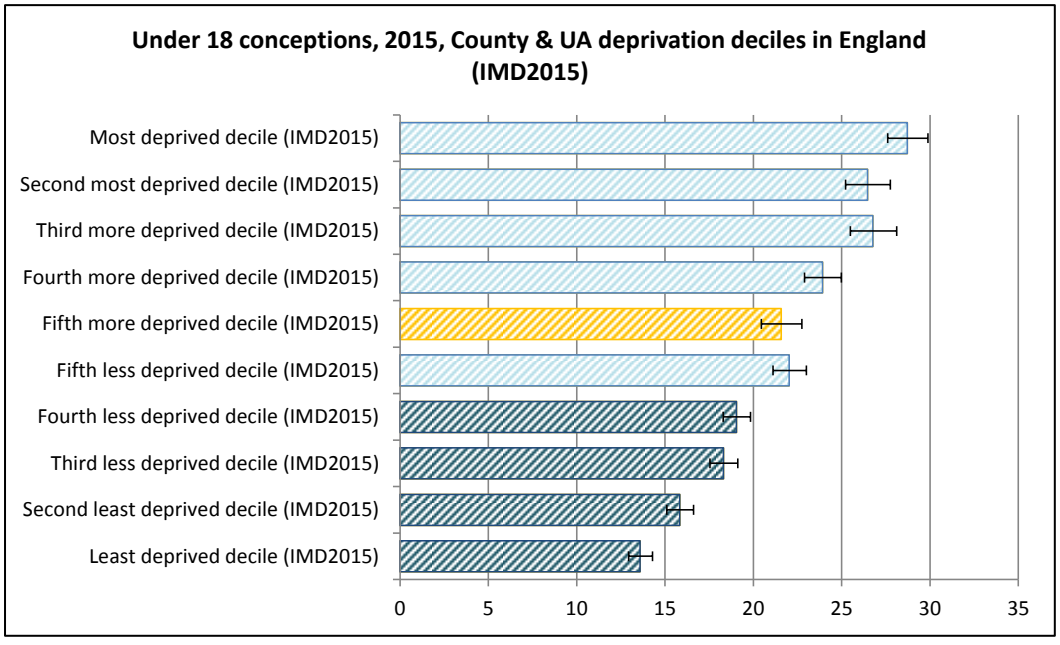


*"**Rationale** – Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS*

Caveats - Conception statistics includes births and legal abortions and do not include miscarriages or illegal abortions. The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. Only about 5% of under 18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as population at risk."

In both NTWD and DTHRW the majority of under 18 conceptions live in the most deprived decile.

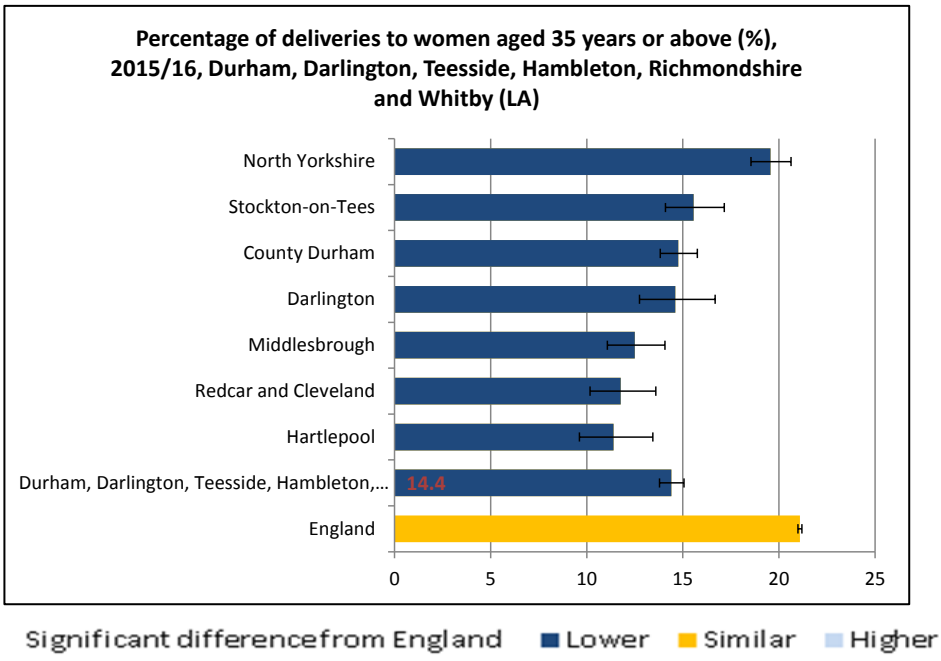
NTWD



Source data: Fingertips – Pregnancy and birth profile, 2015
Link: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy (LMS Service Packs, PHE 2017)

Percentage of deliveries to women aged 35 years or above

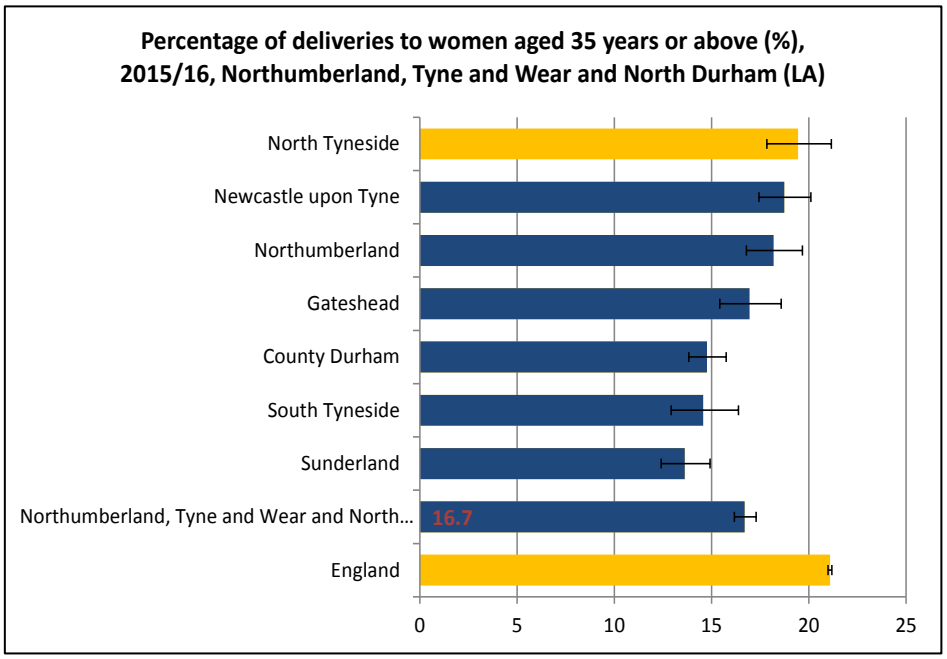
DTHRW



*"**Rationale** – Older mothers are more likely to experience pregnancy complications such as preeclampsia, miscarriage and complicated pregnancies which could result in use of forceps or caesarean section. Multiple pregnancy is also more common, both naturally conceived or as a result of assisted conception. Older mothers are however also more likely than younger mothers to start breastfeeding, and to continue for six months or more (Infant Feeding Survey - UK, 2010. Copyright © 2012, Health and Social Care Information Centre. All Rights Reserved)."*

In DTHRW the average % of deliveries to woman ages 35 and above is 14.4% with North Yorkshire in close comparison to England. In the NTWD region North Tyneside percentage of deliveries to woman aged 35 years or above is similar to those in England. The majority of trusts within NTWD are not significantly lower to those in England.

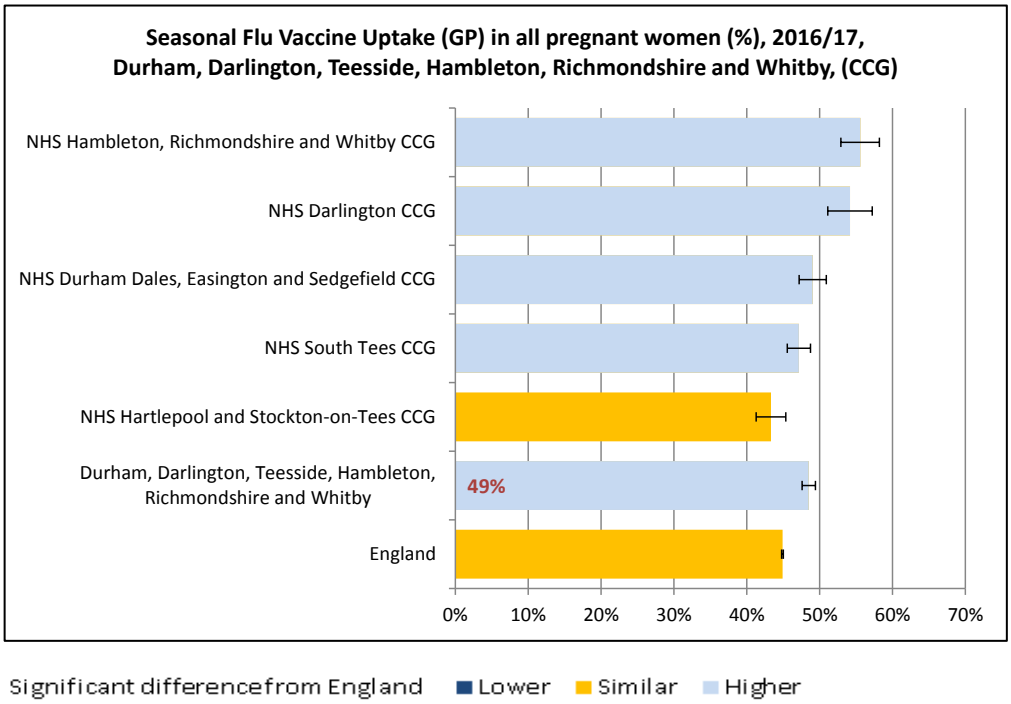
NTWD



Source data: Fingertips – Pregnancy and birth profile, 2015/16
Link: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy (LMS Service Packs, PHE 2017)

Flu vaccinations – pregnant women

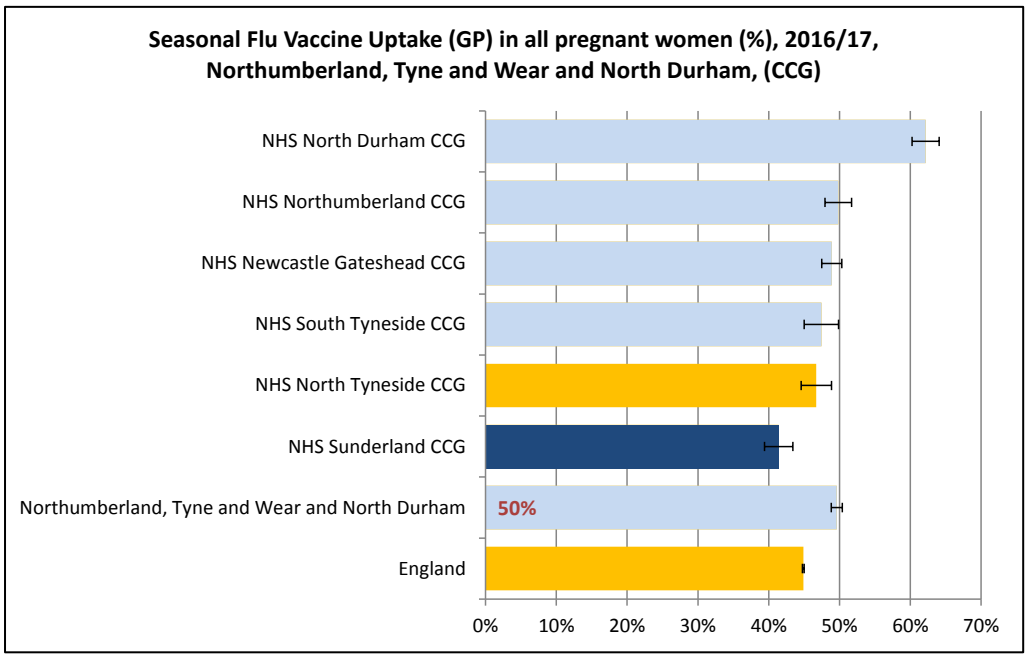
DTHRW



*"**Rationale** – This indicator provides a comparison of vaccination uptake between CCGs. There is good evidence that pregnant women have a higher chance of developing complications if they get flu, particularly in the later stages of pregnancy. One of the most common complications of flu is bronchitis, a chest infection that can become serious and develop into pneumonia. If a woman has flu while she is pregnant, it could mean the baby is born prematurely or has a low birthweight, and may even lead to stillbirth or death. Women who have had the flu vaccine while pregnant also pass some protection on to their babies, which lasts for the first few months of their lives".*

The uptake of seasonal flu vaccine has a very successful uptake rate in comparison to England. All CCG's are achieving between 40%-60% uptake rate in the North Region. North Durham CCG has quite a significant increase in uptake in comparison to CCG's in the Northern region.

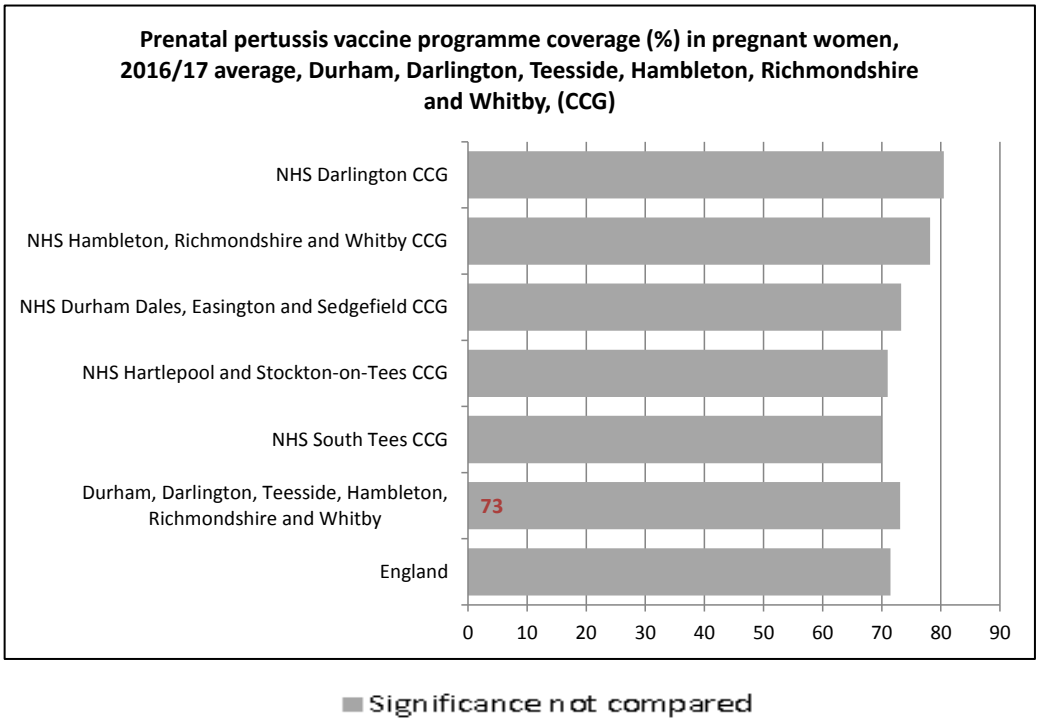
NTWD



Source data: Flu Vaccination data, PHE, 2017
Link: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-in-england-winter-season-2016-to-2017
(LMS Service Packs, PHE 2017)

Pertussis vaccinations – pregnant women

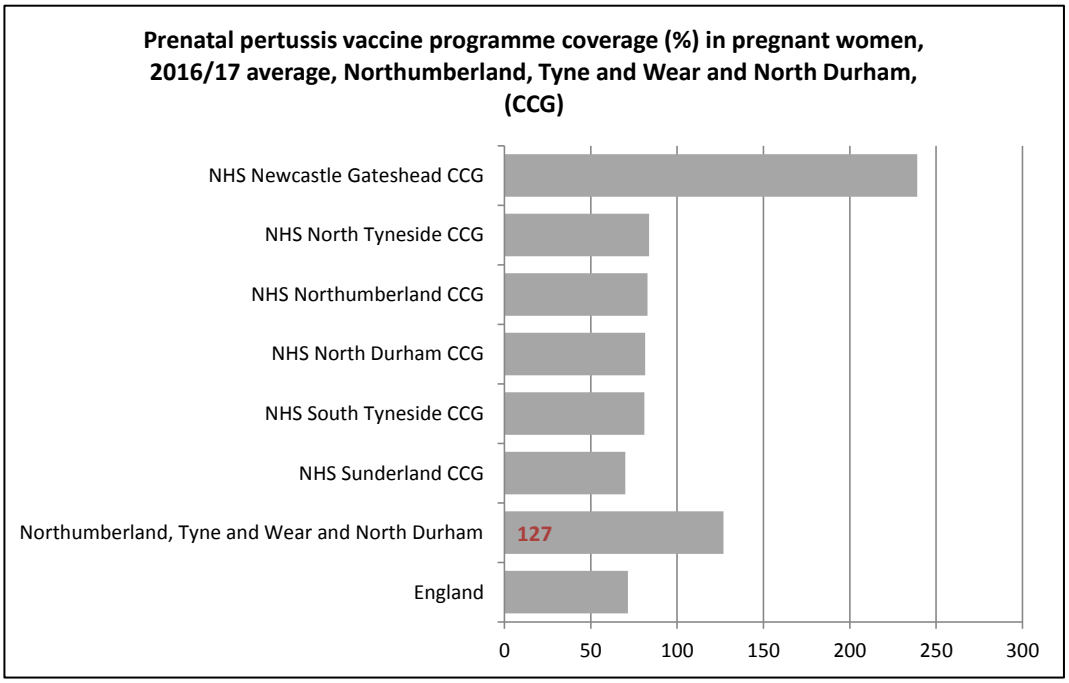
DTHRW



*"**Rationale** – This indicator provides a comparison of vaccination uptake between CCGs. Getting vaccinated while you're pregnant is highly effective in protecting your baby from developing whooping cough in the first few weeks of their life. The immunity you get from the vaccine will pass to your baby through the placenta and provide passive protection for them until they are old enough to be routinely vaccinated against whooping cough at two months old."*

The uptake of prenatal pertussis vaccine is overall higher than in comparison to England. Newcastle Gateshead CCG has quite a significant increase in uptake in comparison to CCG's in the North East.

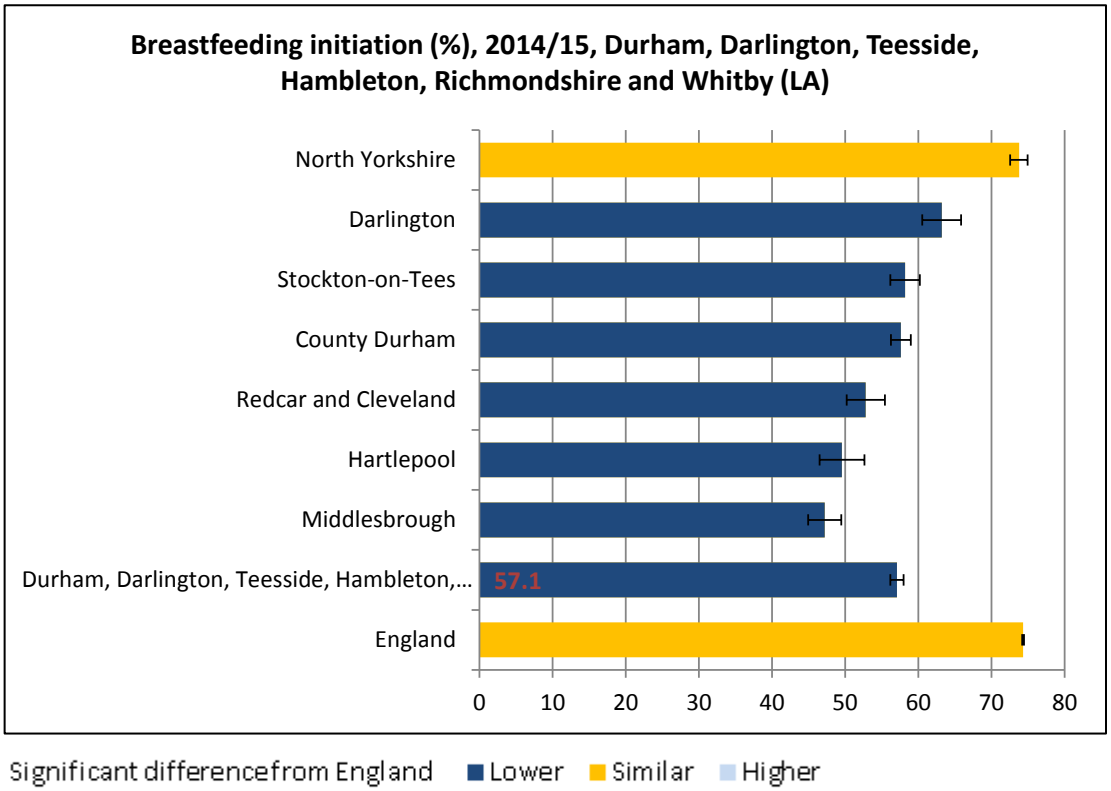
NTWD



Source data: Pertussis Vaccination data, PHE, 2017
Link: https://www.gov.uk/government/publications/pertussis-immunisation-in-pregnancy-vaccine-coverage-estimates-in-england-october-2013-to-march-2014 (LMS Service Packs, PHE 2017)

Breastfeeding initiation rates

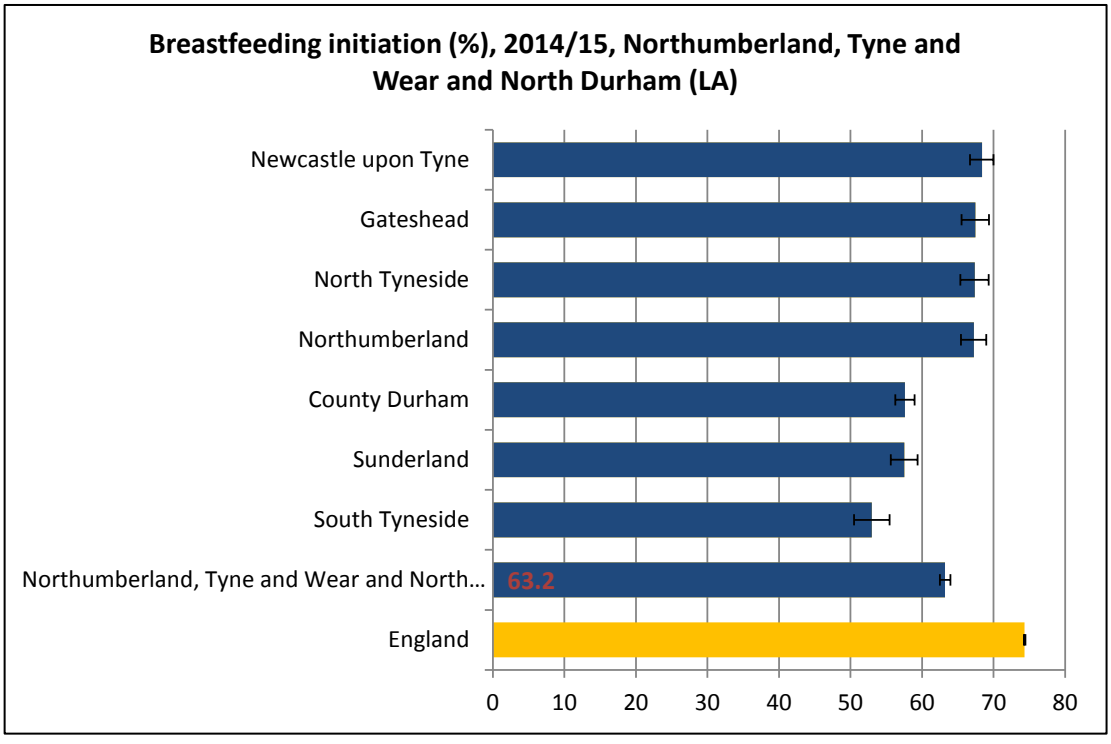
DTHRW



*"**Rationale** – Increases in breastfeeding are expected to reduce illness in young children and have health benefits for the baby and the mother. Rates in the UK are low compared to the rest of the world. This indicator can show local variation."*

Breastfeeding initiation is lower than the England average in both LMS and the most recent data, on the Pregnancy and birth - PHE Fingertips, provides a similar picture.

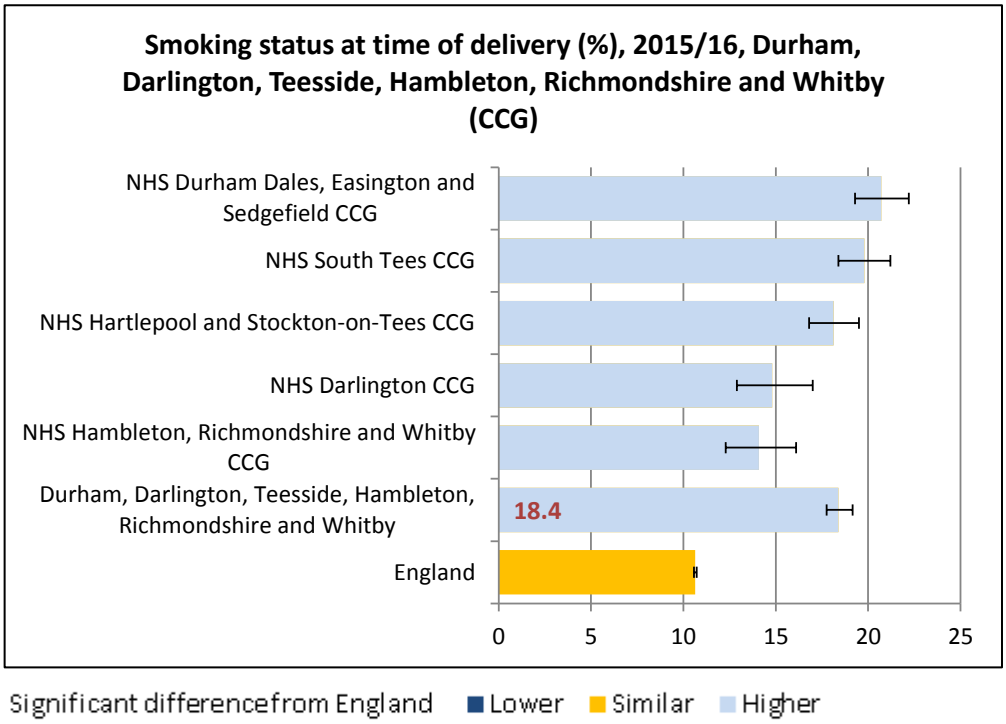
NTWD



Source data: Fingertips – Pregnancy and birth profile, 2014/15
Link: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy (LMS Service Packs, PHE 2017)

Smoking status at time of delivery

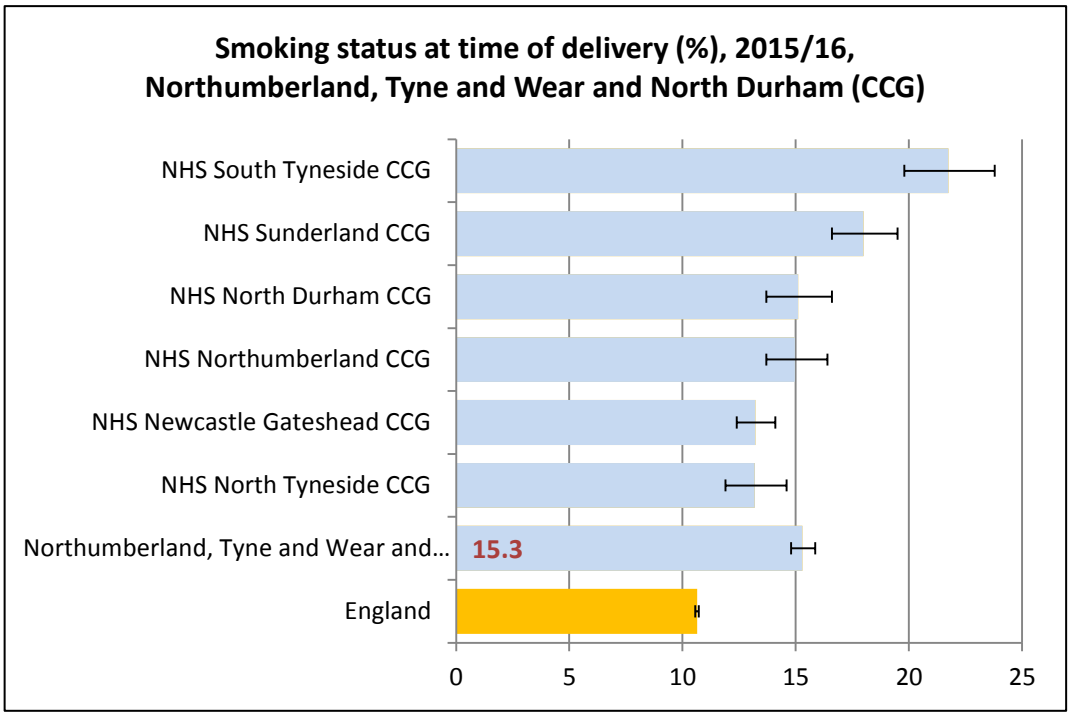
DTHRW



***"Rationale** – Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Smoking during pregnancy can cause serious pregnancy-related health problems including an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy."*

Smoking status at delivery across both DTHRW and NTWD is higher than the England average. Whilst rates are decreasing, see p19, this remains a high priority for both LMS

NTWD



Source data: Fingertips – Pregnancy and birth profile, 2015/16
Link: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy

4. Key Lines of Enquiry: Baseline and Trajectories

Birth projections

LMS	Number of Births			
	Number of births and projection for each year to 2020/2021			
	2015 baseline (Office for National Statistics ONS)	2018/19	2019/20	2020/21
Darlington, Tees, Hambleton Richmondshire and Whitby	12,227	12,549	12,626	12,626
Northumberland, Tyne and Wear and [North] Durham	17,655	18,091	18,237	18,137

(Source data: NHS Digital, 2017 and ONS births, 2015Link: https://digital.nhs.uk/catalogue/PUB24180 and https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths. Projections, (PHE 2018)

The definitions used to develop the ambitions for the key lines of enquiry are those provided in "Measuring levels of ambition at LMS level for Key Deliverables (Maternity Transformation Programme Board November, 2017).

Still Births and Neonatal Deaths and Intrapartum Brain Injuries

LMS	Key Lines of Enquiry							
	A. Are there clear and credible plans to improve 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? (This should include an assessment of the current position and a clear improvement trajectory)							
	Stillbirths and neonatal deaths (rate per 1000 births)				Intrapartum brain injuries			
	2015 baseline (MBRRACE)	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline (Each Baby Counts reported cases*)	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
Darlington, Tees, Hambleton and Richmondshire	**5.4**	**5.1** (5% reduction)	**4.9** (10% reduction)	**4.6** (15% reduction)	**2015 5** 2016 9 2017 7	*5% reduction*	*10% reduction*	*15% reduction*
Northumberland, Tyne and Wear and North Durham	**4.6**	**4.4** (5% reduction)	**4.1** (10% reduction)	**3.9** (15% reduction)	**2015 19** 2016 23 2017 15	*5% reduction*	*10% reduction*	*15% reduction*

(*National Neonatal Research Database NNRD not available)

Definition: *The crude rate of still births and neonatal deaths per 1,000 total births in the table above uses the MBRRACE definitions. "MBRRACE exclude any stillbirths that are a consequence of late (post 24 weeks) termination of pregnancy due to medical reasons and any neonatal deaths associated with a live birth that occurs prior to 24 weeks gestation" The 2015 MBBRACE data was provided to each Local Maternity System with the expectation that "[g]oing forwards, the annual MBRRACE reports are used to measure progress against Local Maternity System ambitions"*

"The national ambition is for there to be a 50% reduction in stillbirth and neonatal mortality rates by 2030 (with an interim milestone of a 20% reduction by 2020) for which DH will be using 2010 ONS data as the baseline. However, the consistent clinical advice from NHS England with regard to the CCG Improvement and Assessment Framework is to use MBRRACE data. Therefore, the 2015 MBRRACE data has been used as the baseline for the purposes of Local Maternity System plans / levels of ambition. Consequently, the level of reduction required to meet the national ambition will be less than the headline figure – on average we expect a 10% reduction in stillbirths and neonatal death rates by 2020 will be sufficient, although we would encourage Local Maternity Systems to go further where possible. Given the variation in stillbirth and neonatal death rates that exists currently [ ] it is recognised that those Local Maternity Systems with the highest rates have the greatest scope for improvement and therefore should be planning for a larger reduction than those with the lowest rates."
(Maternity Transformation Programme Board, November, 2017, p4-5).

NTWD and DTHRW LMS ambitions are in line with the national ambitions.
At the time of setting trajectories, the most the most recent stillbirth rate (2015) in England was 4.4 per 1,000 total births, down from 4.6 in 2014. There has been a general downward trend in the stillbirth rate since 2005 with a decrease of 18.5% over the last 10 years. Despite this, England has higher neonatal mortality and stillbirth rates than many other high income countries. There is also a wide variation in stillbirth rates between different regions' across England.

According to the recent MBRRACE-UK report (2016) the two North East LMS have:

- crude still birth rates that are 10% lower than the England average
- stabilised and adjusted still birth rates that are up to 10% lower than the UK average
- crude neonatal mortality rates that are more than 10% lower than the UK average
- stabilised and adjusted still neonatal mortality rates that are up to 10% lower than the UK average
- crude extended perinatal mortality rates that are more than 10% lower than the UK average
- stabilised and adjusted perinatal mortality rates that are up to 10% lower than the UK average

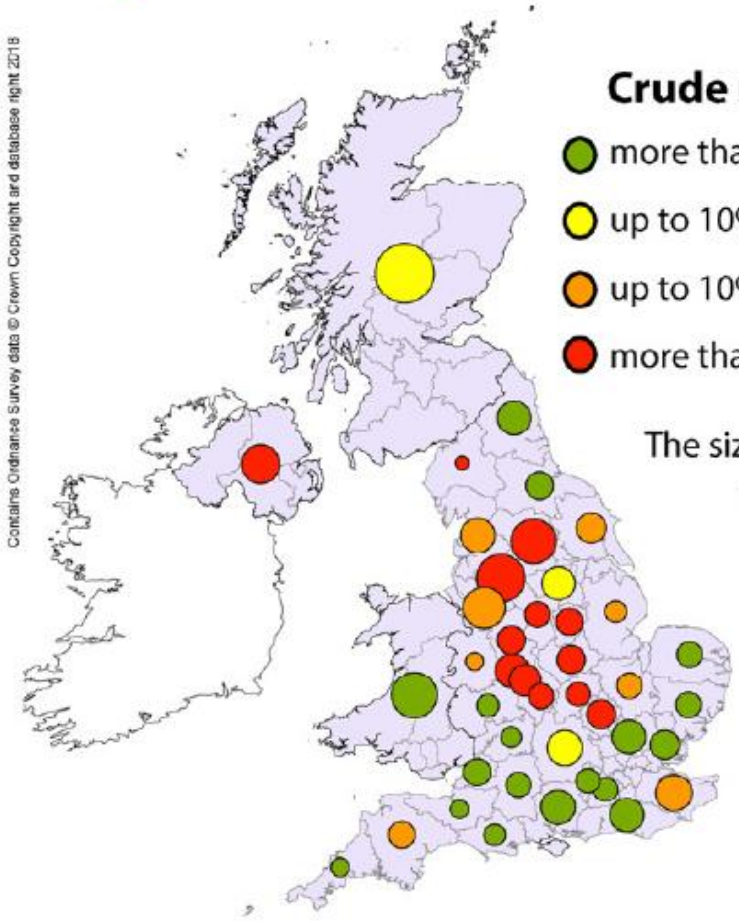
The following four tables are sourced from the following report:

Draper ES, Gallimore ID, Kurinczuk JJ, Smith PW, Boby T, Smith LK, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2016: Summary Report. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2018.

ISBN 978-09935059-9-7

Published by: The Infant Mortality and Morbidity Studies

Regional variation still evident in England



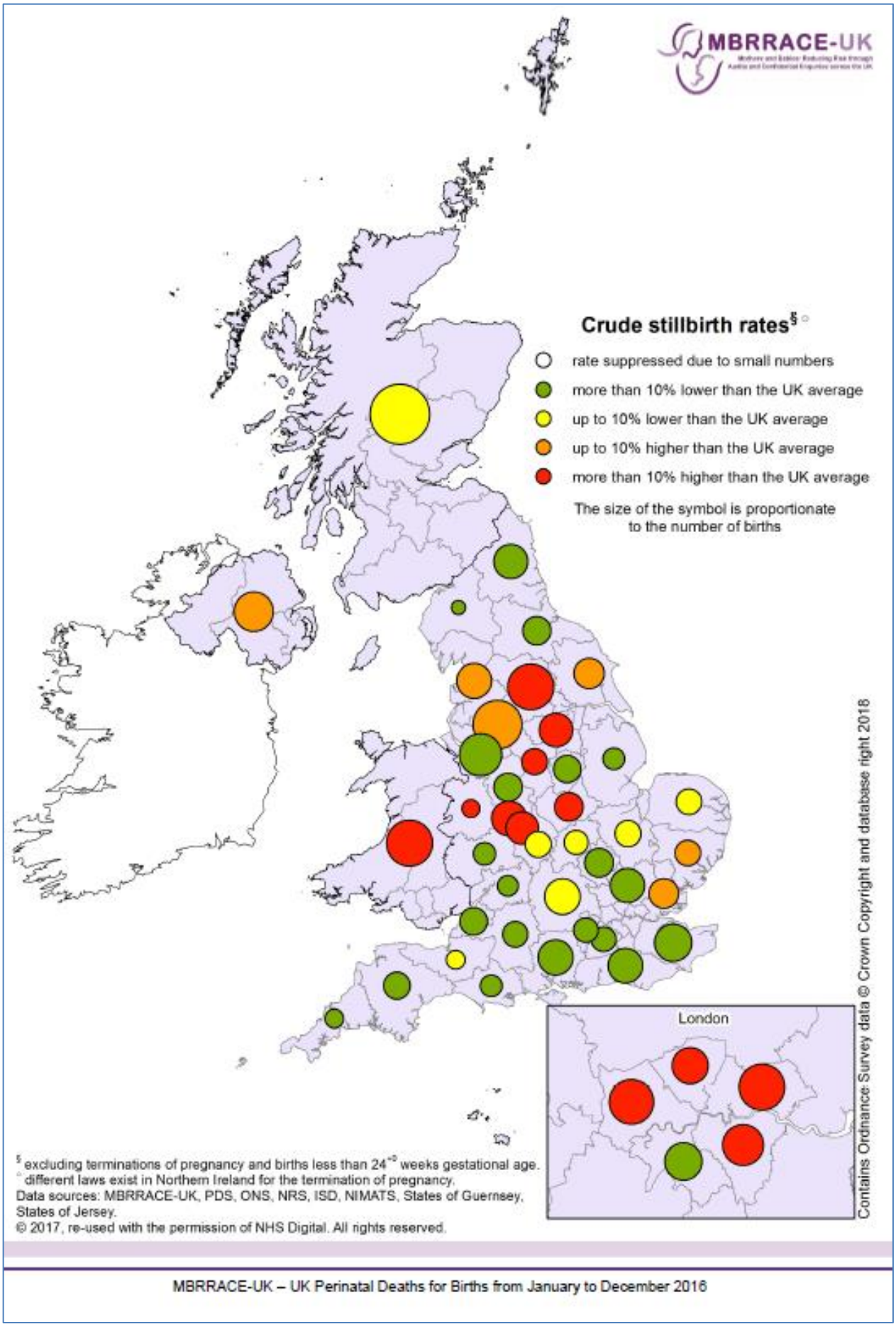
Crude neonatal mortality rates

- more than 10% lower than the UK average;
- up to 10% lower than the UK average;
- up to 10% higher than the UK average;
- more than 10% higher than the UK average

The size of the circle is proportionate to the number of births

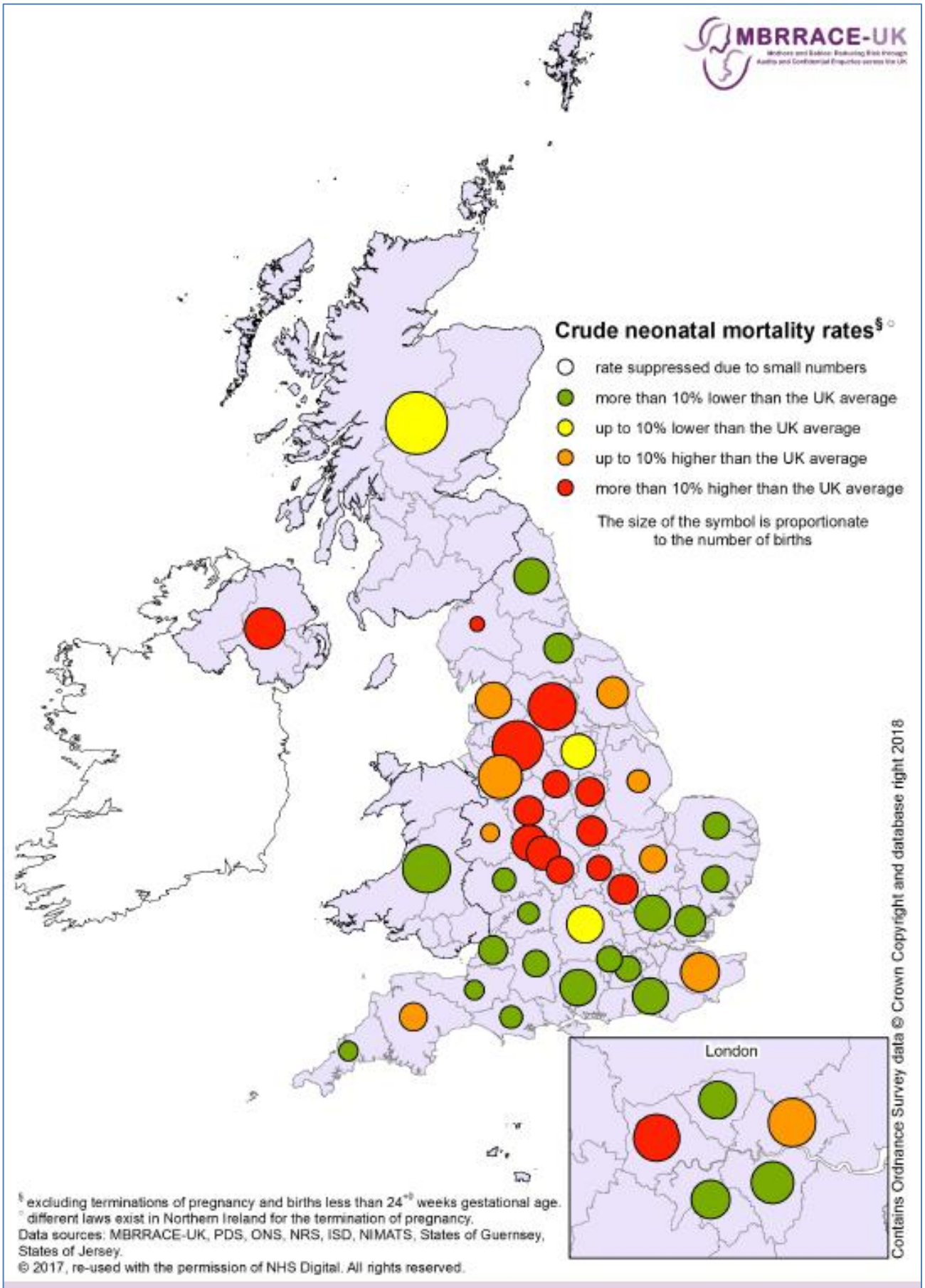
Data by STP Footprint (England) and Country (Scotland, Wales and Northern Ireland)

Crude stillbirth rates by Sustainability and Transformation Partnership (England) and county of residence (Scotland, Wales and Northern Ireland) based on postcode of mother's residence at time of delivery: United Kingdom, for births in 2016.



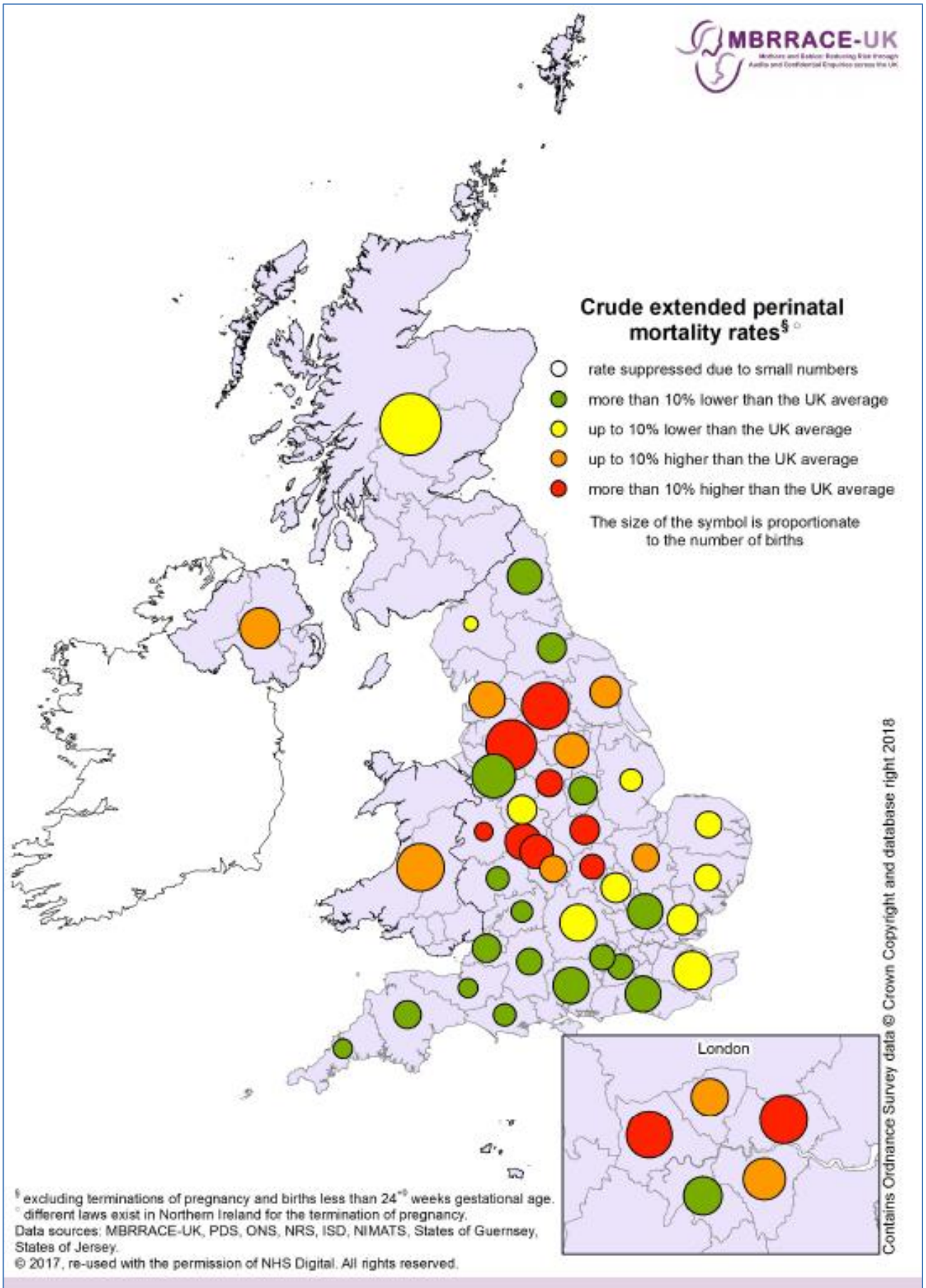
MBRRACE-UK – UK Perinatal Deaths for Births from January to December 2016

Crude neonatal mortality rates by Sustainability and Transformation Partnership (England) and county of residence (Scotland, Wales and Northern Ireland) based on postcode of mother's residence at time of delivery: United Kingdom, for births in 2016.



MBRRACE-UK – UK Perinatal Deaths for Births from January to December 2016

Crude extended perinatal mortality rates by Sustainability and Transformation Partnership (England) and county of residence (Scotland, Wales and Northern Ireland) based on postcode of mother's residence at time of delivery: United Kingdom, for births in 2016.



MBRRACE-UK – UK Perinatal Deaths for Births from January to December 2016

Activity to reduce stillbirths - The Saving Babies' Lives (SBL) Care Bundle
There is a need to both reduce the stillbirth rate overall, in line with other high income countries, and to close the gap between regions at a national level.

The LMS and the Northern England Maternity Clinical Network are working, individually and collectively, to reduce the stillbirth rate via the adoption of the Saving Babies Lives (SBL) care bundle which includes four elements:

Element 1 - Reducing smoking in pregnancy
Element 2 - Detecting fetal growth restriction
Element 3 - Raising awareness of reduced fetal movement
Element 4 - Improving effective fetal monitoring during labour

The Saving Babies' Lives Care Bundle Findings Survey 8

	Northern England Providers carrying out improvement activities	National Benchmark	Northern England Providers at 100%	National Benchmark
Element 1: Smoking in pregnancy	100%	99%	75%	68%
Element 2: Detecting FGR	100%	96%	25%	33%
Element 3: Reduced fetal movement	100%	100%	75%	53%
Element 4: CTG monitoring	100%	100%	100%	58%
All elements	100%	25%	25%	13%

NHS England, December 2017 8 out of 9 providers responded

NHS England conducts quarterly surveys to monitor progress of the SBL care bundle by acute provider trust and significant improvements have been made across the LMS in each of the elements: 1, 3 and 4.

As part of the Maternity Clinical Network dashboard, stillbirth and neonatal mortality rates are collected and monitored on a quarterly basis from each provider trust. This information is shared at the Maternity Network Clinical Advisory group for interpretation and analysis.

Whilst progress has been made, there is still significant improvement required to reach full compliance and this is reflected in the LMS Transformation plans, particularly in the prevention and safety sections.

The LMS and the Maternity Network will be working towards the expectation (NHS planning guidance) that the Saving Babies Lives Care Bundle will be fully implemented by March 2019.

The element requiring most improvement is element 2, detecting fetal growth restriction, specifically having sufficient sonography to implement national screening algorithms and compliance with the need to audit detection rates across the entire Network area.

Each Baby Counts – Network Data

	Year	Intrapartum Stillbirth	Neonatal Death	Brain Injury
Total numbers for North East	2015	2	9	24
	2016	2	12	32
	2017	2	8	22

This table shows the numbers of cases that have been submitted to the Each Baby Counts national team from Northern England acute provider trusts since 2015. These numbers, alongside MBRRACE

data, will be used to inform the LMS baseline position, and how we assess our progress towards the 2020 and 2030 targets.

Intrapartum Brain Injuries
"This refers to the number of infants admitted to a neonatal unit with a number of defined conditions. The data source for estimating the number and rates of brain injuries based on the above definition is the National Neonatal Research Database (NNRD), a summary of electronic patient admissions to neonatal units in England, Wales and Scotland"
(Maternity Transformation Programme Board, November, 2017).

Due to the data source not yet being available the LMS were advised to await publication prior to developing their levels of ambition.

In the interim, crude numbers collected locally for Each Baby Counts submissions have been included above.

Maternal Deaths
Previously, all maternal deaths were reported to the Local Supervisory Authority, which ceased to exist in 2016. There is currently no formal process for collation of these cases and identification of provider trust level data.

Maternal deaths are included in the small list of cases that the Network, Acute Provider Trusts and LMS Boards have agreed should have an external expert clinician present at any case review. This process is managed via the RCA terms of reference and learning from these cases feedback through the Maternity Patient Safety Learning Network for wider sharing of good practice, lessons learnt and for identification of any shared actions required to improve and standardise care. All maternal deaths will eventually be reviewed by the external HSIB process and the Network is fully engaged with the progress and will assist with roll out in our area as appropriate.

The Network has linked with other clinical networks and understands national work around learning from deaths. The Maternal Medicine Group will provide a forum for discussing national reports and recommendations and maintaining an overview of local death cases and themes.

Personalised Care Planning

LMS	Key Lines of Enquiry			
	D. Are there clear and credible plans to roll out personalised care planning as envisaged in section 7.3.2 of the LMS resource pack?			
	Number of personalised care plans			
	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
Darlington, Tees, Hambleton and Richmondshire	0% (0)	25% (3,057)	33% (4,035)	40% (4,891)
Northumberland, Tyne and Wear and North Durham	0% (0)	25% (4,414)	33% (5,826)	40% (7,062)

At present, all North East provider trusts offer personalised care plans to women, according to the definition in Better Births resource pack (March, 2017). In particular this means that they should:

- *"Record*
  - What is important to the woman and her family
  - The health needs of the woman and her baby
  - The decisions she makes about the care and support she receives.
- *Cover the antenatal, intrapartum and postnatal phases of care.*
- *Be based on an ongoing dialogue with her midwife and, where appropriate, obstetrician.*
- *Be kept up to date as the pregnancy progresses and in line with assessments around risk and the mother's and baby's health and wellbeing.*
- *Includes strategies to help each woman manage her own health"*

However, it is acknowledged that personalised care plans are likely to be variable across providers – and even within the same organisation, and for example there might be occasions when not every element of the documentation is complete.

No national data is currently available on personalised care plans however NHS Digital have been asked to include this in the pending update to the MSDS, but this is likely to take at least another 18 months before the data starts flowing.

As the LMS do not currently have a way to demonstrate that personalised care plans meet the definition above, the baseline is considered as 0%. However having reviewed the personalised care sections within hand held maternity notes, every provider demonstrates opportunity for choice conversation and birth planning.

Activity to improve personalised care planning:
LMS will follow the actions outlined in the LMS Transformation Plan to achieve 25% of woman having a personalised care plan by end of 2019; 33% by 2020; 40% by 2021 and 100% in 2025. These level of ambitions refer to the numbers of women who will have all elements of personalised care plan completed.

Lay representatives are engaging with women to understand their perception of personalised care plans.

Maternity choice digital booklet will be made available to all women across all three Local Maternity Systems in Northern England, outlining the maternity offer across the 3 LMS and providing opportunities to discuss and document their personalised care choices.

Number of women able to choose from three places of birth

	Key Lines of Enquiry			
LMS	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. (This must include a baseline of current choice offer and a clearly stated ambition.)			
	Number of women able to choose from three places of birth			
	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
Darlington, Tees, Hambleton and Richmondshire	100% (12,227)	100% (12,227)	100% (12,227)	100% (12,227)
Northumberland, Tyne and Wear and North Durham	100% (17,655)	100% (17,655)	100% (17,655)	100% (17,655)

Definition: *"The number of women able to choose from three types of birth location. This means the number of women to which in theory a Local Maternity System can offer a choice of Obstetric Unit (OU), Midwifery Unit - Freestanding Midwife Led Unit (FMU) or Alongside Midwifery Unit (AMU) or Co-Located Midwifery Unit, or Home Birth Service – in practice a woman with complications may not feel that a choice between all three settings is realistic for her, but it is the availability of three types of units that is important" (Maternity Transformation Programme Board, November 2017)*

The NICE Guideline 2017, Intrapartum care for healthy women and babies (CG190) indicates that healthcare professionals, midwives, should help women to make an informed choice about where to have their baby.

The three places of birth offer are:
Obstetric units - maternity care is provided by a team of midwives and doctors; there is antenatal care provision for women with certain medical conditions or who develop complications during pregnancy, in the form of obstetrician-led clinics and inpatient facilities. Obstetric units provide care to women at low and at higher risk of complications and all women are cared for by midwives during pregnancy, birth and after the birth. Midwives have primary responsibility for providing care during and after labour to women at low risk of complications, while obstetricians have primary responsibility for women who are at increased risk of, or who develop complications. Diagnostic and medical treatment services (including obstetric, neonatal and anaesthetic care) are available on site.

Midwife-led units - midwives have primary responsibility for care during labour in women at low risk of complications. Midwife-led units can be freestanding or located alongside an obstetric unit:

- Freestanding midwife-led unit (FMLU): a midwife-led unit which is not located on the same site as an obstetric unit. If obstetric, anaesthetic or neonatal care is needed, women will be transferred to an obstetric unit by ambulance.

- Alongside midwife-led unit (AMLU): a midwife-led unit located on the same site as an obstetric unit and which therefore has access to the same medical facilities if needed. Women will normally be transferred to the obstetric unit if they develop complications or wish to have an epidural. An AMLU may be in a different building, or it may be in a designated area within an obstetric unit. An AMLU should be branded as a MLU and care pathways will demonstrate that women are cared for by a midwife lead professional.

According to the data available on Which birth choices (https://www.which.co.uk/birth-choice/where-to-give-birth) 100% of women across the North East are able to choose from three places of birth.

The LMS ambition is to maintain the current status of 100%. Although it is recognised in practice a woman with complications may not feel that a choice between all three settings is realistic for her, but it is the availability of these three types of unit that is the definition.

Activity to improve how we offer choice:
Despite the potential of 100% choice, the survey indicators in the CCG IAF for the two LMS indicate that 100% of women do not feel that they are being offered choice. An important aspect of this workstream is to understand these survey findings. An engagement exercise is being led by lay representatives of the LMS Boards to understand whether local women feel that they are supported in making an informed choice about their place of birth. The findings from their work will enable the LMS to shape how services offer choice.

Maternity choice digital booklet will be made available to all women across all three Local Maternity Systems in Northern England, outlining the maternity offer across the three LMS and providing opportunities to discuss and document their personalised care choices.

Continuity of Carer

	Key Lines of Enquiry			
LMS	**F. Is there a local ambition 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? (This should include current position and project numbers of women receiving continuity over agreed period.)**			
	Number of women receiving continuity of carer during pregnancy, birth and postnatally			
	Local baseline	**Trajectory March 2019**	**Trajectory March 2020**	**Trajectory March 2021**
Darlington, Tees, Hambleton and Richmondshire	**1.6% (196)**	**20% (2,446)**	**25% (3,057)**	**40% (4,891)**
Northumberland, Tyne and Wear and North Durham	**1.3% (230)**	**20% (3,531)**	**25% (4,414)**	**40% (7,062)**

As this data has not been collected previously locally or nationally, the above baseline should be treated with caution as it is has been calculated from https://www.which.co.uk/birth-choice/where-to-give-birth with the assumption that home birth may be provided through a team midwifery model.

The ambition to increase continuity of carer by 20% by March 2019 is stated in the NHS planning guidance 2018/19 and the LMSs are striving towards this ambition.

NHS England (NHS planning guidance 2018/19) has advised that the aim is to:

> "Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally, so that by March 2019, 20% of women booking receive continuity. This means that 20% of women at booking must commence on a pathway to receive continuity of carer throughout antenatal, intrapartum and postnatal periods."

Evidence will be taken from booking data rather than evidence that Continuity of Carer has taken place after the postnatal period.

Principles and definition of continuity of carer (NHS Implementing Better Births: Continuity of Carer, December 2017)**:**

Principles:

1. Provide for consistency of the midwife and/or obstetrician who cares for the woman throughout the antenatal, intrapartum and postnatal periods
2. Include a named midwife who takes on responsibility for co-ordinating a woman's care throughout the antenatal, intrapartum and postnatal periods
3. Enable the woman to develop and ongoing relationship of trust with her midwife
4. Where possible be implemented in both the hospital and community setting

The Definition
"There are two main models [as well as a mix of the two] which meet these principles which Local Maternity Systems will want to consider for implementation locally:

1. *Team continuity, whereby each woman has an individual midwife, who is responsible for co-ordinating her care, and who works in a team of four to eight, with members of the team acting as backup to each other. This allows for protected time, during which the other members of the team will provide unscheduled care, and the lead midwife will not be called upon. The woman gets to know all the members of the team, so at the time of the birth she has met all of its members.*
2. *Full caseloading, whereby each midwife is allocated a certain number of women (the caseload) and arranges their working life around the needs of the caseload. The backup is provided by a core midwifery team whom the woman is unlikely to have met."*

Number of women giving birth in midwifery settings

	Key Lines of Enquiry			
LMS	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)?			
	Number of women giving birth in midwifery settings			
	Local baseline 2017	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
Darlington, Tees, Hambleton and Richmondshire	11.4% (1390)	*13% (1590)*	*15% (1834)*	*15% (1834)*
Northumberland, Tyne and Wear and North Durham	11.7% (2067)	*13% (2295)*	*15% (2648)*	*15% (2648)*

Definition: *The number of women that gave birth at home or in midwifery units (Maternity Transformation Programme Board, November 2017)*

In the absence of a central national data source, to establish a baseline for the number of women giving birth in midwifery units and at home, the DTHRW LMS and NTWD LMS have used Which? Birth Choice to triangulate local data sources.

Each LMS provides 100% of women with choice to three places of birth, having reviewed catchment data on https://www.which.co.uk/birth-choice/where-to-give-birth. There will be proactive work in partnership with service users to ensure that women feel that they are receiving informed choice and that the workforce has all the information they need to support discussions about choice.

Evidence for increasing midwifery led care

The NICE guidance advises that planning to give birth at home or in a midwifery unit is particularly suitable for women who have straightforward pregnancies or who have already had a baby. For women with straightforward pregnancies who are expecting their first baby, it is advised that planning to give birth in a midwifery unit is particularly suitable, but that there is a small increase in risk for the baby if they plan birth at home.

The National Childbirth Trust (NCT) has indicated the following advantages of having a baby at a midwifery led unit:

- Being in surroundings where the woman may feel more relaxed and able to cope with labour.
- The woman is more likely to be looked after by a midwife that they have got to know during their pregnancy.
- Usually the woman will be able to be in the same room for their whole stay, with their partner and not moved to another ward/area.
- More likely to have a straightforward birth without medical interventions.

The midwife led continuity model of care has been reviewed by Cochrane and the evidence has shown that there are better outcomes for patients, which reflect the benefits NCT have identified. The main benefits were that women who received midwife led continuity of care were less likely to have an epidural, episiotomies or instrumental births. The research has indicated that women's chances of a spontaneous vaginal birth were also increased in a midwifery led unit and there was no difference in the number of caesarean births. Cochrane review has stated that women were less likely to experience preterm birth, and they were also at a lower risk of losing their babies. They also reinforced the ideal care package for women giving birth in a midwife led unit were more likely to be cared for in labour by midwives they already knew.

Local interpretation of how the LMS will meet the ambition

There are discussions locally for and against setting of targets for number of women giving birth in midwifery settings. There is some concern it has the potential to impact negatively on choice by introducing an incentive for directive counselling in favour of giving birth in a midwifery setting.

The over-riding principle of care should be that women have full (appropriate) informed choice regarding place of birth, based on high quality counselling and the provision of unbiased information (as stated in 'Better Births'). Each LMS are working towards ensuring that all women are provided with appropriate, standardised and unbiased information. This may lead to a cultural change that will increase the number of women choosing to give birth in a midwifery setting; however there will be some women for whom it is inappropriate to recommend giving birth in a midwifery setting for reasons of greater than usual risk to themselves and / or their babies.

It might still be reasonable to include a level of ambition for a small increase in the numbers of women giving birth in midwifery-led settings, in recognition of the facts that (a) there is evidence of significant benefits associated with low risk women choosing to give birth in such settings, and (b) a recent local survey has shown that more women would like to give birth in midwifery settings than is currently the case.

Having set these trajectories the LMS will need to consider capacity issues - does each LMS have enough midwife led units? And how will the LMS establish what is a reasonable distance for women? This will include consideration of transferability between units, historical acceptance of travel, level of

deprivation, car/public transport availability, impact on ambulance transport and measure of babies born before arrival.

National picture for prevalence of midwifery led care
The National Maternity and Perinatal Audit, Organisational Report 2017 (NMPA), summarised that maternity and neonatal service configuration is subject to constant change, with half of NHS trusts and CCGs reporting planned or anticipated changes in the next 3 years. It is documented that there has been a steady increase in the number of alongside midwife-led units, which have quadrupled during the last decade. Two thirds of obstetric units are now co-located with an alongside midwife-led unit. A fifth of trusts offer the full range of birth settings (home, freestanding midwife-led unit, alongside midwife-led unit and obstetric unit) and three quarters offer homebirth, at least one of the midwife led unit types, and obstetric units.

The NMPA shows that two thirds of British obstetric units are now co-located with an alongside midwife-led unit (68% in England, 38% in Scotland and 100% in Wales). In England, the number of obstetric units has decreased by 13% since 2007 and although individual freestanding midwife-led units have opened and closed, the overall number increased by 13% during this period. The NMPA highlighted that in some areas, geographical factors may impact on the feasibility of providing all the choices for women.

The NMPA highlights that 77% of trusts offer homebirth, at least one of the midwife-led unit types, and an obstetric unit. However, 19% do not have any midwife-led units and 3% do not have any obstetric units. The NMPA advised that Trusts and their commissioners where applicable, should collaborate across geographical areas to ensure all women have access to all three birth settings as this would correlate with the recommendations within the Better Births report.

The NMPA has shown that obstetric units and alongside or co-located midwife led units were particularly common in densely populated areas, while freestanding midwife-led units were often located in rural and remote areas.

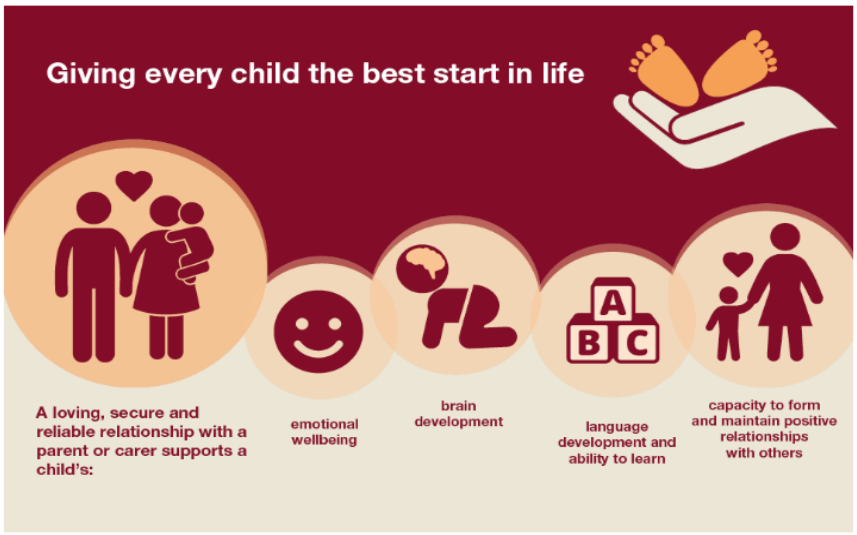
Local picture for prevalence of midwifery led care
On researching the local maternity units in Cumbria and North East area there are some obstetric and alongside units that are co-located, in that they share the same ward area and may only be divided by a curtain or a designated section of the ward. Accountability and responsibility for the women in the midwife led area may be blurred when co-located as there is no clear separation as with freestanding and alongside units.

The research and information do highlight that midwife led care is cost effective but ultimately patients should be able to make an informed decision and have the choice of facilities available. The LMS will focus on safety, patient choice and working collaboratively to improve outcomes for maternity services. The Better Births review has suggested that Community Hubs working in an existing midwife led unit would act as a ‘one stop shop’ for women and provide access to all services through the maternity care pathway.

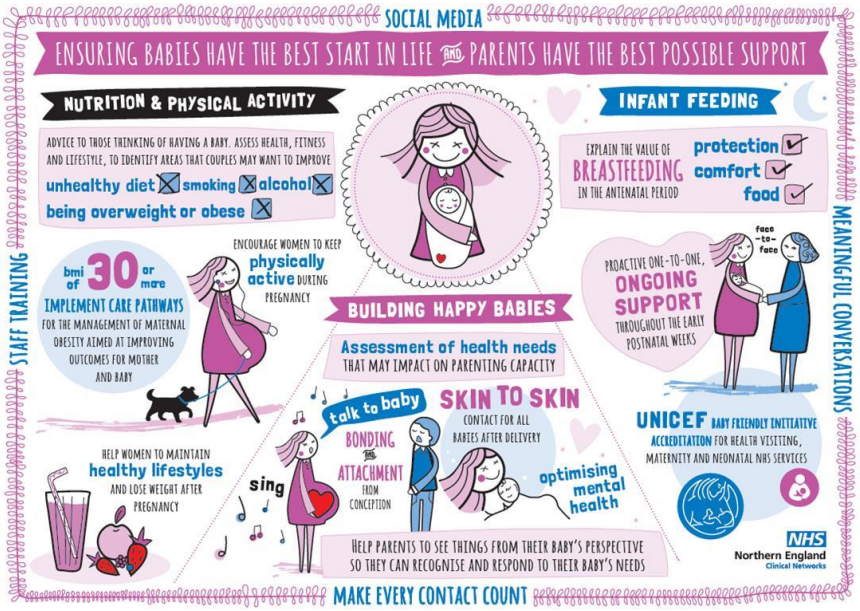
Prevention and Public Health Interventions

The LMS has described its public health ambitions in the LMS Transformation plans, aware of the low rates of: breastfeeding initiation and breastfeeding prevalance at 6-8 weeks after birth; high rates of smoking at time of delivery; high rates of deprivation; high numbers of teenage mothers and relatively high numbers of under 18 conceptions. The STP has prioritised:

Best start in life



Source: Public Health England (2016) Health Matters: giving every child the best start in life at https://publichealthmatters.blog.gov.uk/2016/05/12/health-matters-giving-every-child-the-best-start-in-life/



Interventions that can be implemented by service providers aimed at optimising infant mental health, promoting and supporting breastfeeding and supporting healthy weight and healthy lifestyles for pregnant women.
Source: Northern England Maternity Clinical Network (2017)

Serious Incidents in Maternity Services

Plans 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 relative wider learning shared through the Local Maternity System and with others.

Plans include:

- **Implementation of the Saving Babies Lives Care Bundle which has both process and outcome measures**
  Implementation of Saving Babies Lives is included in the national audit which gives a very broad overview asking if there are any quality improvement initiatives taking place. However, this doesn't ask for any evidence or provide any detail, good practice, measurable outcomes etc. acute provider trusts must show compliance at Board level for CNST (Clinical Negligence Scheme for Trusts) reduction so the Network can request this and provide to the LMS.

- **Use of the perinatal mortality review tool**
  Compliance is needed for CNST standards. There have been presentations and discussions in network wide forums and locally in advance of its launch and acute provider trusts are starting to use it.

- **Participation in the Each Baby Counts and Maternal and Neonatal Health Safety Collaborative**
  All acute provider trusts are involved in these improvement activities, supported by the Maternity Clinical Network and Academic Health Science Network.

- **Serious Incident (SI) processes - trusts grouping similar SIs together and looking for common themes**
  The Route Cause Analysis (RCA) process implemented locally has helped initiate this; an example is a regional review of shoulder dystocias, following a common trend in SI cases.

- **Missed Congenital Anomalies**
  The work NCARDAS (National Congenital Anomalies and Rare Diseases register) are doing helps to close the audit cycle when anomalies are picked up at delivery, which haven't been detected in the antenatal period. NCARDAS have recently started reporting out to acute provider trusts on their data and have done a lot of work to try to get access to acute provider trusts IT systems to collect accurate outcomes. The data is also helping acute provider trusts/national teams to report on the 11 auditable conditions which are screened for at the anomaly scan.

  Regarding Downs, Edwards and Pataus syndrome screening (combined and quad testing) the regional lab also tries to follow up pregnancies (screen positive and negative) and have links with the Genetics lab for outcomes to match the data.

  From a screening perspective acute provider trusts are not asked to report missed anomalies via national screening reporting systems/national guidance as programmes are screening and not diagnostic and therefore have a chance to miss some conditions screened for e.g. detection rates for 4 major cardiac anomalies is around 50% nationally. Acute provider trusts would report missed anomalies via their own internal reporting mechanisms and usually discuss at internal audit meetings. This is a process we would look for at the QA visits in part because sonographers to share learning and improve process.

- **Compliance with MBRRACE's recommendations from their Perinatal Mortality Reports and relevant NICE recommendations e.g. aspirin treatment in pregnancy**
  This action will be picked up by the Maternal Medicine group once re-established with new lead in September.

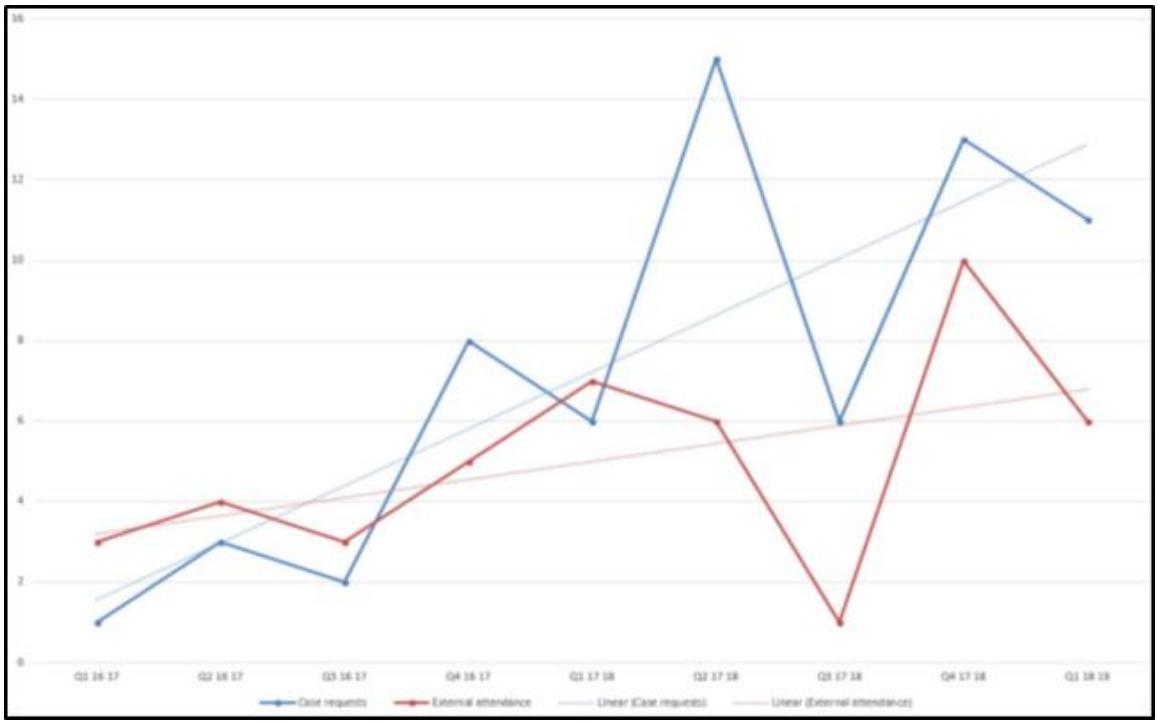
Maternity Patient Safety Learning Network

The Northern England Maternity Clinical Network set up the Maternity Patient Safety Learning Network (MPSLN) in November 2015, in advance of the publication of Better Births. The group brings together representatives with an interest in risk management and patient safety from across the Network.

Membership of the group is responsible for implementing changes and service development within their own areas and teams. Members include: Anaesthetics; Clinical Governance; Obstetrics; Local Supervising Authority; Maternity Clinical Network; Midwifery; Patient Safety; Perinatal Mental Health; Trust Risk Management

As part of the MPSLN, provider trusts work alongside the Maternity Network to gain representation and attendance at External Root Cause Analysis Panels:

- A list has been agreed of those cases that warrant mandatory external attendance from provider trusts.
- Agreement has been secured at the MPSLN for each provider trust to submit a brief summary of each serious case review to include the actions learned. The reports will be collated in advance of each meeting, during which there will be a conversation about key issues that merit wider conversation
- The Network currently holds a list of 42 external root cause analysis forms with 26 lessons learnt and actions.
- Currently formalising the process of matching the skill set of the external reviewer to that required for a better analysis of the case.
- Exploring optimum ways of disseminating and sharing actions learned. Sharing of lessons learnt via MPSLN meetings and patient safety events and support provided from AHSN Communications team to produce lessons learnt safety bulletins.
- Formal Terms of Reference have been produced, supported by all three LMS boards
- Dedicated email address set-up to coordinate RCA requests



The graph shows the increase in number of case requests and external attendance from quarter one 2016/17 to quarter one 2018/19

Outcomes of external review process
This process has grown and developed and all of the 9 acute provider trusts in the Network have recognised the merits of the approach, each becoming involved in requesting and providing external panel members.

More than 40 clinicians have attended case reviews and have brought numerous lessons learnt back to the MPSLN meetings for further sharing across the network area. In some cases where external members have not been available, we have been able to provide a paper external review of notes and accompanying review reports.

The success of this process has led to a steady increase in requests for volunteers, which has meant that there has been a need to develop a more robust, formal terms of reference, administrative support and monitoring and a plea for increased numbers of experienced clinicians to join the review team pool.

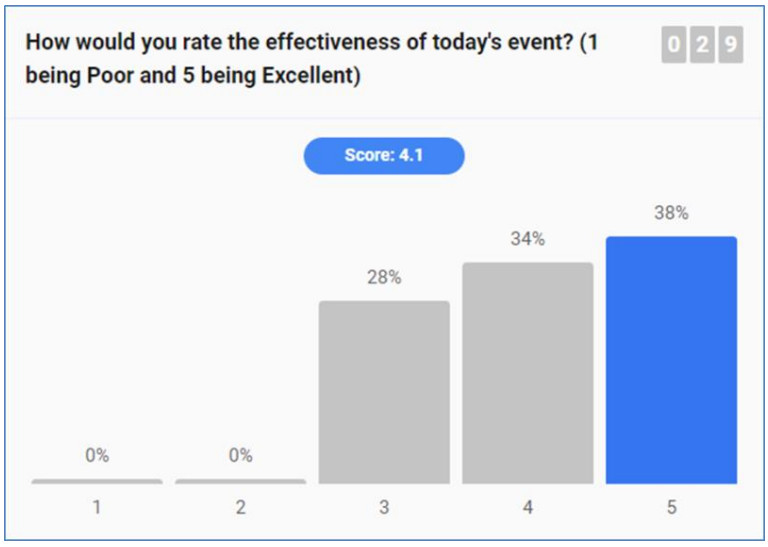
The new TOR were approved by all three LMS boards and the Network Clinical Advisory group, Heads of Midwifery and Maternity Patient Safety Learning Network. They were formally presented at the regional patient safety event with accompanying case reviews and learning shared.

We have linked closely with similar work on-going in other Clinical Networks to share best practice ideas and have open attendance at learning events to discuss cases and share safety messages and examples of excellent care widely

Positive outcomes from this developing process are;
(a) Improved networking, collaboration and relationships between neighbouring organisations,
(b) value added by independent voices at identified case reviews leading to improvement and standardisation of the review process across the region,
(c) identification of incident themes for further review on a region-wide basis and wider sharing of lessons learnt and good practice via the MPSLN meetings,
(d) The MatNeo collaborative work including links to the neonatal network, and
(e) Production of regular region-wide patient standardisation of the review process across the region

Participation in the NHS Improvement Maternity and Neonatal Health Safety Collaborative
The Collaborative, the Neonatal Network and the Maternity Clinical Network are working together to take advantage of each other's knowledge and expertise for example:

The Maternity Network co-hosted an event with the Academic Health Science Network on 23rd January 2018 to launch the Maternity and Neonatal Health Safety Collaborative across the area. The meeting was well attended with 73 delegates, including a good mix of obstetric, midwifery, neonatal and senior management staff. A summary of the effectiveness of the event is detailed below.



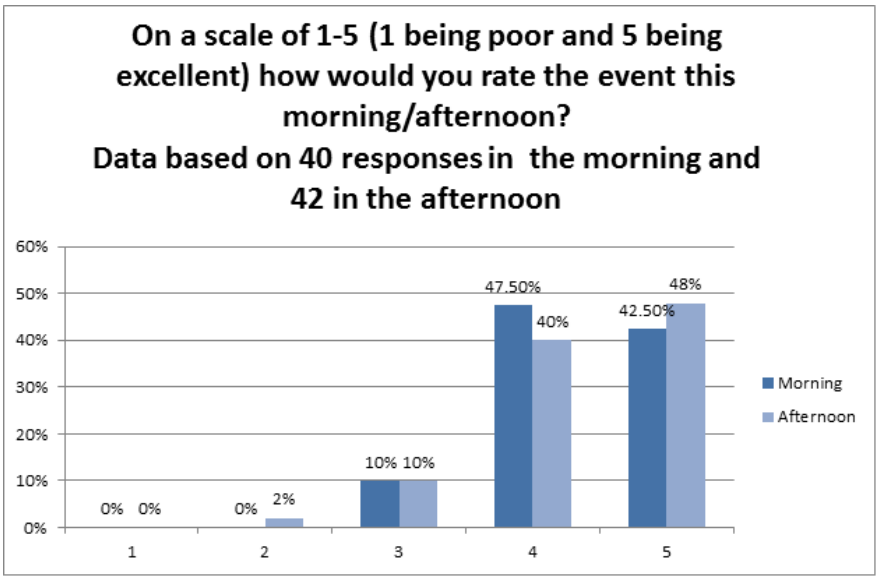
As part of the event the Northern England Maternity Clinical Network produced a data pack to aid trusts when making decisions around the elements they wish to focus on as part of the collaborative.

The acute providers taking part by waves:

- Wave 1 - North Tees and Hartlepool
- Wave 2 - County Durham and Darlington, Gateshead, Northumbria, and South Tees
- Wave 3 - Newcastle, North Cumbria and Sunderland

A 2nd Maternal and Neonatal Regional Patient Safety Event was co-hosted by the Maternity Clinical Network, Academic Health Science Network, North East and North Cumbria MatNeo Safety Collaborative and the Northern Neonatal Operational Delivery Network. The event held on 22nd May 2018 attracted over 80 attendees and the agenda included:

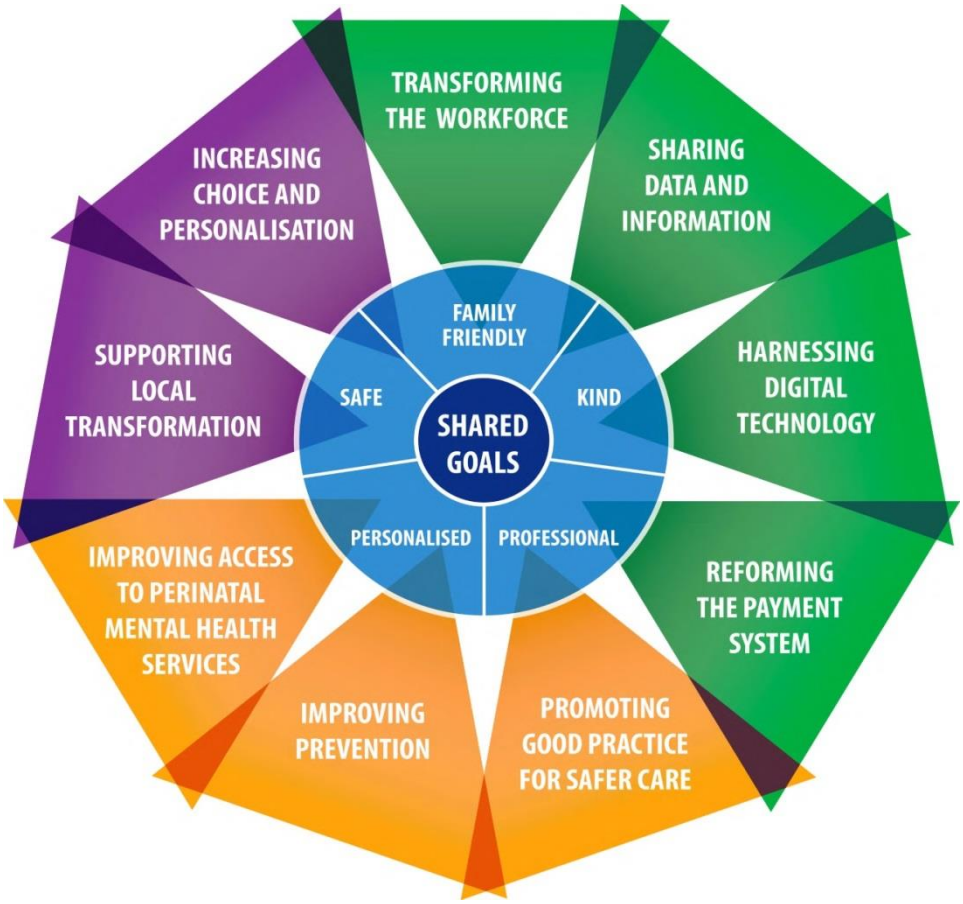
- Reducing Term Admissions: A Neonatal Perspective
- Establishing Transitional Care in County Durham and Darlington NHS Foundation Trust
- Learning from regional RCAs
- Key messages from NHS Resolution, including Early Notification Scheme
- Insights from the Health Safety Investigation Branch
- PReCePT National Programme - What we know so far
- Overview of MatNeo Collaborative
- Project Ideas: Wave 2 Sites
- Learning so far: Top tips and takeaways from Wave 2 sites
- The Model for Improvement
- North Tees and Hartlepool NHS Foundation Trust Project Progress and Top Tips for SCORE Culture Survey and
- Joining the Virtual MatNeo Collaborative Learning System for North East and North Cumbria



5. How the Local Maternity System will achieve the Vision

"Local transformation supported by national enabling action is key to realising the Better Births vision".

Nine national programme work streams are supporting the implementation of Better Births locally:



Nine national programme workstreams, NHS England

The LMS Maternity Transformation plan will be achieved through a whole system approach embracing shared leadership and accountability. The LMS will share and learn from best practice and work collaboratively to achieve the vision set out in Better Births.

The Local Maternity Transformation Plan

The Maternity Transformation Plan sets out how the LMS will deliver Better Births by the end of 2020/21:

Providers and commissioners operate as a Local Maternity System, 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.

Plans are based on 4 considerations:

1. An understanding of the local population and its needs from maternity services
2. An analysis of the gap between current service provision and the vision set out in Better Births
3. Alignment with other local plans.
4. The financial case for change

The plan is co-produced with service users and staff who will work together to implement it. It is a live document and will be reviewed and updated. It will be the vehicle for implementation and will be supported by ongoing programme/project management with regular progress monitoring and reporting.

Co-production - Stakeholders and Partnership Working

When we use the term co-production, we mean involving people who use health and care services, carers and communities in equal partnership; engaging with people at the earliest stages of service design, development and evaluation. This approach has been adopted through LMS transformation planning as co-production is essential to successful implementation.

The plan is based on an understanding of the needs of local women and their families and the Maternity Clinical Network have established a Maternity Engagement Group (MEG) in July 2017, to link up Maternity Voices Partnerships and other parent groups across the Network, to support the LMS to engage women and their families in the delivery of Better Births.

The MEG is focusing first on advising on personalised care plans, continuity of carer and developing a Network wide digital choice booklet. The MEG will also take account of previous local consultations with women and families led by commissioners, and the innovative ways of seeking feedback being practised within provider trusts.

An NCT Voices training day was funded by LMS and held November 2017. The aim of the day was to build effective and productive user engagement via Maternity Voices Partnerships in the North of England. By taking part in this event, participants will be better able to:

1. Explain the changes within maternity services
2. Identify ways in which they can improve co-production at both a local and regional level
3. Make the case for change at both MVP and LMS level
4. Develop new ways of gathering parent feedback
5. Build strong support networks

Lay representatives have been appointed for each LMS. They co-chair the Network Maternity Engagement Group and sit on LMS Boards.

A baseline assessment of Maternity Voice Partnerships across the LMS has been carried out in order to understand what is working well in each locality and where any support may be needed. A number of gaps have been identified where there are no MVP and the MEG will work with the LMS to seek to address this.

Capacity and capability to implement the LMS Transformation plan
Across the LMS and the STP there is the capability and capacity to implement the transformation plans utilising the transformation monies.

Finance

The LMS has considered, and will keep under review, the financial implications of their plans, including overall affordability, transition and any recurrent costs, as well as how maternity transformation contributes to the wider STP.

There are some important elements of the LMS transformation plan which will alter the cost base of the service, if the LMS is to meet the ambitions in the NHS planning guidance. These particularly include continuity of carer and maternity hubs.

For maternity hubs significant development work is required with local authority partners to identify both the model and the cost, this will be subject to future business case consideration. Continuity of Carer models, similarly, will be developed following engagement exercises and piloting of different models. As the models are further developed detailed costing will be incorporated into updated versions of the plan.

National Tariff
It is understood that there will be no changes to national Maternity Pathway Payment (MPP) in 2018/19. There are three main actions being proposed for the 2019 / 21 MPP:

1. Unbundling specialised fetal medicine
2. Changing the payment design for the delivery phase
3. Updating the complex factors for the postnatal phase

The LMS is encouraged to consider whether/ how the MPP is a barrier to transformation and apply local variations as per the tariff rules. Examples are provided of local variations that might be used to support transformation:

- to support single point of access
- to increase choice in the antenatal phase
- later clinical decision making around the choice of location of birth

In the long term it is anticipated that a reduction in litigation costs, and reduced smoking and alcohol consumption will reduce the costs of maternity care and be reinvested in maternity care.

NHS England Maternity Transformation Programme funding
NHS England Maternity Transformation Programme funding in 2017/18 (£150,000 per LMS) has enabled the LMS to backfill project management and administrative support from the Maternity Clinical Network, as well as clinical leadership. In addition to the maternity improvement work that the system already has underway, the transformation funding has enabled:

- Maternity Voices Partnership (MVP) lay representatives support to the LMS Boards;
- NCT voices training for MVP;
- baseline audits contributing to the prevention workstream;
- perinatal mental health training (IHV);
- baseline audits of smoking and alcohol consumption in pregnancy
- preparation within providers for continuity of carer and community hubs;
- further engagement work with women, including with vulnerable women and birth reflection service
- Gestation Related Optimal Weight (GROW) study day.

NHS England Maternity Transformation Programme funding in 2018/19 (£150,000 per LMS and £403,000 for NTWD LMS and £ 267,000 DTHRW LMS) allows the LMS to build on the work that commenced in 2017/18 and in particular develop and test out models of Continuity of Carer and maternity hubs. Proposed budgets are included below:

Budgets to support delivery of NTWD LMS plan 2018/2019

	NTWD LMS - PMO Project/Clinical Backfill Funding source: NHS England Maternity Transformation		
	Budget 18/19		**£150,000**
			Estimated costs £
0.5	LMS Midwife	Band 8b	40,000
0.25	Backfill of Network Administrator	Band 4	7,300
0.1	Backfill Network project support to Maternity Engagement group	Band 7	5,500
0.5	LMS Programme Management		45,200
	Medical backfill for LMS NTWD		0
0.5	LMS Prevention Coordinator (funded from 17/18 budget)		0
	Project/Clinical Backfill to support the objectives of the workstreams in the LMS plan		6,000
	Contribution to events (prevention, perinatal, LMS wide, maternity engagement)		5,000
	Comms & design support		10,000
	Maternity Engagement (expenses and meetings)		3,000
	Travel/expenses		8,000
	Backfill to run project to listen to the voices of hard to reach women in maternity services (Newcastle).		10,000
	Backfill to roll out birth reflection service (Northumbria)		10,000
	Total £		**150,000**

	NTWD LMS - Transformation Funding source: NHS England Maternity Transformation		
	Budget 18/19		**£403,000**
			Estimated costs £
	Continuity of Carer proposals (see more detailed breakdown below)		370,000
	Backfill to improve continuity of care for mothers with Gestational and Insulin dependent diabetes (Gateshead)		10,000
	Backfill to support plans to develop Better Births Community Hub (South Tyneside)		10,000
	Backfill to enable local midwifery workforce to facilitate high risk mothers with improved continuity of care (Sunderland)		10,000
	Project/Clinical backfill to support the objectives of the workstreams in the LMS plan		3,000
	Total £		**403,000**

	NTWD Continuity of Carer plans - Budget 18/19 Funding source: NHS England Maternity Transformation Programme **Agreement LMS wide to provide Continuity of Carer for diabetic women and also develop pilots for vulnerable women taking into account the findings from the workforce engagement exercise and staff feedback.**		
			£
	Funding agreed to support implementation of team continuity plans to cover cost of Band 7 plus contribution to administrative costs for each provider:		**370,000**
	Sunderland – Women with diabetes, Raised BMI and Elective C-Sections		61,648
	Northumbria – Women with diabetes, Freestanding Midwifery Led Units in Berwick, Alnwick and Hexham		61,648
	Newcastle – Women with diabetes		61,648
	Gateshead – Women with diabetes and Teenagers and Young Adults		61,648
	South Tyneside – Low risk women who choose to deliver in the Freestanding Midwifery Led Unit		61,648
	Durham – Women with diabetes		61,648
	Total £		**369,888**

Budget to support delivery of DTHRW LMS plan 2018/2019

	DTHRW LMS - PMO Project/Clinical Backfill		
	Budget 18/19 Funding source: NHS England Maternity Transformation		**£150,000**
			Estimated costs £
0.5	LMS Midwife	Band 8b	40,000
0.25	Backfill of Network Administrator	Band 4	7,300
0.1	Backfill Network project support to Maternity Engagement group	Band 7	5,500
0.5	LMS Programme Management		45,200
	Medical backfill for LMS NTWD		0
0.5	LMS Prevention Coordinator (funded from 17/18 budget)		0
	Project/Clinical Backfill to support the objectives of the workstreams in the LMS plan		26,000
	Contribution to events (prevention, perinatal, LMS wide, maternity engagement)		5,000
	Comms & design support		10,000
	Maternity Engagement (expenses and meetings)		3,000
	Travel/expenses		8,000
	Total £		**150,000**

	DTHRW LMS Transformation Funding- Funding source: NHS England Maternity Transformation		
	Budget 18/19		**£267,000**
	Additional midwifery and maternity support worker capacity for each locality (three) to support delivery of LMS plans (with a focus on Continuity of Carer pilots)		196,755
	Project/Clinical Backfill to support the objectives of the workstreams in the plan		70,245
	Total £		**267,000**

	DTHRW Continuity of Carer plans - 18/19 **Agreement LMS wide to provide Continuity of Carer for diabetic women and also develop pilots for vulnerable women taking into account the findings from the workforce engagement exercise and staff feedback.**		
	Funding agreed to support implementation of team continuity plans to cover cost of Band 7 plus contribution to administrative costs for each provider:		**£196,755**
	South Tees – All women cared for by maternal medicine team: women with diabetes, endocrine and essential hypertension. Teenage pregnancy MLU		65,585
	North Tees and Hartlepool – Women with diabetes		65,585
	Darlington – Women with diabetes		65,585
	Total £		**196,755**

Transformation proposals that were developed but are currently not funded /fully funded DTHRW

Title	Aim	Estimated Cost £
MDT Continuity of care for 19 and under	Proposal to implement a 12 month pilot of multidisciplinary team to provide continuity of care for women aged 19 and under (approx. 150) during the antenatal, intrapartum and postnatal period including extending post-natal care and support to 6 weeks.	176,743
Towards a digital record	Project manager/analyst to work across the three providers to undertake a review of the current systems in place both electronic and paper based. The project manager would be supported by an administrative function and would be required to work across boundaries reporting into the LMS Board the findings of the review. This would enable the LMS to consider future requirements to achieve an interoperable maternity record across the LMS patch.	85,424
Supporting Personalised Care Development of New Roles – Pilot of the Baby Support Worker in the Community Setting	Baby Support Workers (BSW) have been successfully introduced into the hospital setting at CDDFT to support transitional care, infant feeding and promote bonding and attachment. The introduction of the BSW has reduced term admissions to the Neonatal Unit, increased parent satisfaction and confidence in caring for their babies and released midwifery time to focus on midwifery tasks. The proposal is to develop and expand the BSW role into the community setting to support parents in their own home. The role will also forge links with 0-19 years services improving care for vulnerable babies and supporting the delivery of the vulnerable parent's pathway.	106,860
	Total £	**369,027**

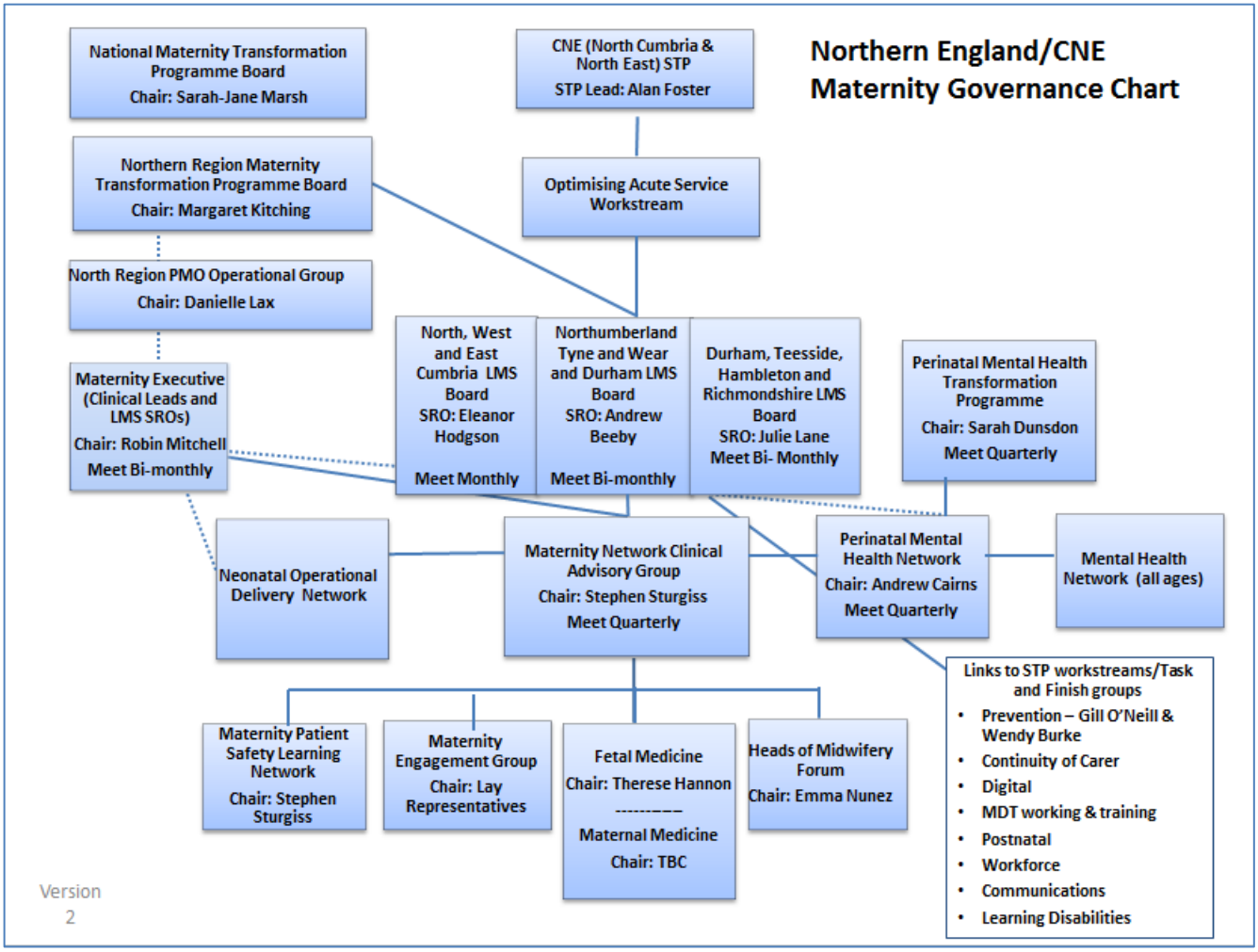
NTWD LMS 2018/19 – certain aspects of these proposals have been funded

Title	Aim	Estimated Cost £
A transformational personalised care pathway for pregnant women with complex needs.	Invest in additional midwifery and maternity health care assistants support for women (100 – 150) with social complexity. The aim is to increase continuity of care and carer, to achieve better outcome in terms of maternal and new-born physical, social, emotional and mental wellbeing	200,000
Transforming the local midwifery workforce to facilitate confident and expert teams to implement improved continuity of care in 2020	Invest in the preparation and training of the current midwifery workforce by developing their cognitive and clinical /practical experience in the delivery of low risk midwifery care, with a specific focus on promoting and embedding continuity of care and carer.	439,080
	Total £	**639,080**

Prevention transformation proposal developed for both NTWD and LMS

Title	Aim	Estimated Cost £
What makes interventions in pregnancy effective (or not) at changing behaviour?	Funding requested for a research associate to carry out a mixed methods systematic review to identify what makes behaviour change interventions effective (or not) at changing obesity/smoking/alcohol-related behaviours in pregnancy. The review will inform the development of a logic model to support the delivery of evidence-based practice and implementation of behaviour change public health guidelines in pregnancy. This will also provide a basis for integrating intervention development, implementation and evaluation.	76,000 – 100,000

Governance Structures and Delivery Mechanisms



Local Maternity System Boards

The Local Maternity System (LMS) Boards have been established in line with national recommendations, and with a governance structure that includes the relevant elements of the local STP.

The aims of the LMS Boards are to develop and implement a local vision for transforming maternity services by 2020/21, based on the principles of the National Maternity Transformation Programme (Better Births 2016).

The Boards are the mechanism through which the Sustainability and Transformation Partnerships (STPs) will collaboratively transform maternity services, with a focus of delivering high quality, safe and sustainable maternity services and improved outcomes and experience for woman and their families.

LMS Teams

DTHRW LMS Team

Senior Responsible Officer:	Julie Lane, Director of Nursing, Patient Safety and Quality, North Tees and Hartlepool Foundation Trust
LMS Midwifery Lead:	Lynne Young
Lay Representative:	Abi Witherden
LMS Prevention Coordinator:	Rebecca Scott
Administrative Support:	Naomi Tinnion (Maternity Network)
Programme Management:	Vicci McGurk (Maternity Network)

NTWD LMS Team

Senior Responsible Officer:	Andy Beeby, Medical Director, Consultant Obstetrics and Gynaecology, Gateshead Health NHS Foundation Trust
Clinical Lead:	Stephen Sturgiss
LMS Midwifery Lead:	Kathryn Hardy
Lay Representative:	Sarah Wall
LMS Prevention Coordinator:	Rebecca Scott
Administrative Support:	Naomi Tinnion (Maternity Network)
Programme Management:	Vicci McGurk (Maternity Network)

Clinical leadership and project management for the majority of LMS workstreams is provided through Maternity Clinical Network, Perinatal Mental Health Network and Neonatal Network groups.

DTHRW Governance Structure

The LMS Board is the mechanism through which the STP will collaboratively transform maternity services, with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes and experience for woman and their families.

Accountability

The LMS Board is accountable to both CNE STP and NHS England through its membership of the North Region Maternity Transformation Programme Board. The LMS Board will report into the North Region Maternity Transformation Programme Board on progress against the LMS action plan, including on activity, quality monitoring, benchmarking and audit and allowing significant risks and issues to be escalated where appropriate.

Assurance of the programme will be undertaken by NHS England through the National Maternity Transformation Programme Board and Maternity Transformation Programme Board (North) in conjunction with the sub regional Directorate Commissioning Offices (DCOs).

Aims and Responsibilities of the LMS Board:

The aims of the LMS Board are adopted and adapted from NHS England's values.

- Provide assurance of the highest standards and seamless care for women, babies and their families
- Ensure that the LMS Board is owned by the organisations
- Encourage collaboration and sharing of best practice and learning
- Review variation in clinical outcomes or other aspects of service quality or efficiency, define targets for improvement, choose appropriate clinical indicators for monitoring and develop strategies to achieve such improvement
- Ensure equitable service provision across the LMS network
- Agree a common clinical governance structure and improvement approach to identify and rectify areas for improvement across pathways or within the LMS network, so that optimum outcomes are achieved

- Develop, review and ratify evidence based standards of care, guidelines and pathways (developed or supported by relevant professional bodies) to promote standardisation of best practice and principles across the partnership
- Achieve clinical consensus on standards, outcomes and care pathways across organisational boundaries and on models of care
- Collaborate and advise on workforce planning, workforce projections, joint education and training to ensure that the consensus approved models of care are safely and effectively implemented
- Promote and integrate research activities
- Provide information to the public/media and ensure public engagement in the LMS network at all levels
- Each member of the LMS Board has a responsibility to disseminate learning along with any relevant issues and information from and to the groups they represent.

The responsibility of the LMS Board is to implement the vision in Better Births by 2020/21 by establishing a Local Maternity System to design and deliver maternity services across boundaries with the intention:

- by March 2017 create an LMS coterminous with the STP footprint and involving all commissioners and providers of maternity services
- by October 2017 establish a shared vision and LMS action plan to implement Better Births by the end of 2020/21
- By 2020/21 deliver the LMS Board action plan outcomes ensuring that work is completed within required timescales

NTWD Governance Structure - Collaborative working and service remodelling

The Local Maternity System (LMS) Board has been established in line with national recommendations, and with a governance structure that includes the relevant elements of the local STP.

The overarching terms of reference for the LMS Board include the following aims:

- The development of proposals to be put forward to the Transformational Delivery Group of the NTWD STP footprint for the strategic development of maternity and neonatal services across the area. These plans will demonstrate how services can be transformed in a way that is clinically and financially sustainable for the next 15 - 20 years.
- The development and implementation of a local vision for collaboratively transforming maternity services by 2020/21, based on the principles of the National Maternity Transformation Programme (Better Births 2016).
- Implementation of the recommendations within the RCPCH Review of the Northern Neonatal Network (2015)

Aims and Responsibilities

Wherever possible the recommendations made by the LMS Board will seek to ensure that they:

- Provide services closer to home, reducing the need for hospital care, allowing people to recover at home, live as independently as possible and achieve their wishes within their community
- Be proactive in care planning – reducing crisis
- Work together in multidisciplinary teams (MDTs) – reducing duplication and improving co-ordination
- Apply clinical standards in a uniform manner across NTWD with provider CQC ratings of good or above
- Ensure patients are able to receive care in the setting most appropriate to their needs
- Ensure the health and care workforce increases its capacity through building recruitment, developing skill-mix and collaborative working
- Ensure patients are able to receive the most appropriate care every day of the week
- Ensure specialisms provided in-hospital have the appropriate expertise, skills and capacity

- Ensure urgent and emergency care is streamlined and easy to navigate
- Take account of current and planned approaches to medical education to support clinically sustainable services
- Agree clinical standards and supporting metrics - including the delivery of the national 7 day standards, agreed measures for mental health and where appropriate consideration of NHS RightCare metrics
- Develop an optimal vision for the configuration of maternity services, taking into account the changes that are predicted to take place in the workforce over the next 5-20 years

Other examples of collaborative working within the area include a formal alliance between two of the acute sector provider trusts (Sunderland and South Tyneside), who have developed proposals to redesign several services, including those for women and babies.

All providers are working together to increase the choice and service offer to families across the footprint - provision of standard care locally with easy clear transfer to specialist services when required.

Governance and Oversight

The LMS Board exists as part of the STP Optimal Use of the Acute Sector (OAS) work programme and reports to the OAS Transformation and Delivery Group. The work of the Transformation and Delivery Group is overseen by the Executive Delivery Group of the STP.

The LMS Board is the mechanism through which the STP will collaboratively transform maternity services, agreeing an STP wide proposal with a focus of delivering high quality, safe and sustainable maternity services and improved outcomes and experience for woman and their families – within a model of care that is sustainable, improves productivity and reduces the demand burden.

The LMS Board will ensure:

- It encompasses the nationally agreed terms of reference for establishment of an LMS in its work programme and governance arrangements and
- Reporting is consistent to both the STP Transformation and Delivery Group and the Maternity Transformation Board (North).

North Region Maternity Transformation Programme Board (MTPB)

The scope of this group is to oversee the Maternity Transformation Programme (MTP) across the region, ensuring that the vision set out in “Better Births” (2016), and the local components of the Maternity Transformation Programme are delivered in line with the NHS Planning Guidance and NHS England’s business plan 2017-18 to 2018-19.

Core Objectives:

- Ensure LMSs develop credible local transformation plans that are linked to STPs and assure those plans by providing appropriate scrutiny and challenge;
- Ensure there is a tailored support package for each LMS, according to their need and circumstances, working with the national maternity policy team and the Clinical Networks;
- Support the Clinical Networks to carry out their function of facilitating the development and implementation of local transformation plans;
- Monitor implementation of local transformation plans throughout the life of the MTP;
- Provide a forum for discussion of operational progress, best practice and regional risk management;
- Provide feedback to the national programme so that it can take account of experiences with local implementation;

Core Responsibilities:

- Providing regional leadership and governance for the operational elements of the MTP;
- Working closely with the national maternity policy team and other NHS organisations;
- Translating national policy and trajectories for regional dissemination and implementation;
- Ensuring relevant risks to the delivery of *Better Births* recommendations are escalated to the MTP and then onto the relevant group;
- Promoting maternity transformation and providing an effective route of communication to LMSs;
- Linking with the STP process;
- Making constructive challenge;
- Resolving problems and brokering solutions;
- Facilitating the sharing of best practice, particularly by helping those at an earlier stage of transforming maternity service to learn from the most advanced;
- Supporting innovation;
- Support offer to Local Maternity System developments regarding Patient Experience and Engagement

North Regional PMO Operational Group

An operational working group of the North Region Maternity Transformation Programme Board (MTPB) to ensure that NHS England delivers on its responsibilities in relation to Better Births and the refreshed planning guidance which was released in November 2017 planning guidance attached here. Engagement to be undertaken with Programme managers across all 9 LMSs along with representation from the National team where necessary to build a single level approach to delivery of the LMS plans and the achievement of the Key Lines of Enquiry.

General responsibilities of the group

The core group membership will comprise of appropriate representatives from across all 9 LMSs, Regional and National representation providing expertise and system leadership to build a single level approach.

The group will adopt a shared learning approach to identify solution and implementation and build on national, regional and local best practice to be shared.

The sub-group is responsible for:

- Overseeing progress against an agreed work plan;
- Managing risks and issues and escalating as appropriate;
- Disseminating information to appropriate stakeholders ;
- Ensuring that the group work plan remains on course to deliver its outcomes;
- Report, escalate issues and make recommendations to the North Regional Maternity Transformation Board.

Both the Network and LMS attend these North Region meetings; disseminating and taking learning from across all nine LMS’s in the North Region and embedding locally.

Attend, contribute and embed learning from the North Region Continuity of Carer working group. Utilise the Maternity Dashboard for baseline data and measuring quality improvements.

North Region Continuity of Carer Working Group

Established as a task and finish group of the North Regional Maternity Transformation Programme Board (MTPB) to ensure that NHS England delivers on its responsibilities in relation to Continuity of Carer, following the release of the refreshed planning in November 2017.

The group will provide expertise and system leadership to build a single level approach and adopt a shared learning approach and build on national, regional and local best practice to be shared.

The sub-group is responsible for:

- Overseeing progress against an agreed work plan;
- Managing risks and issues and escalating as appropriate;
- Disseminating information to appropriate stakeholders;
- Ensuring that the group work plan remains on course to deliver its outcomes.
- Report, escalate issues and make recommendations to the North Regional Maternity Transformation Board

Northern England Maternity Clinical Network

The two aims of the Maternity Clinical Network are:

- To share information, best practice and learning, to benchmark and drive improvement in the quality of services across the region; and
- To ensure that specialist services are available to women and babies with more complex needs, and that they receive consistently high quality treatment in centres with the right facilities and expertise, as close to their home as possible.

Responsibilities of the Maternity Clinical Network are:

- Providing advice to commissioners
- Reducing unwarranted variation in experience and outcomes
- Promotion of best practice and innovation

The Northern England Maternity Clinical Network works in close partnership with Local Maternity Systems and is an important source of support by:

- Providing ongoing clinical input and expertise
- Supporting Local Maternity Systems to establish themselves, and draw up and implement local maternity transformation plans.
- Helping Local Maternity Systems understand and interpret national policy for local implementation
- Supporting benchmarking of the quality of services and spreading good practice
- Supporting strategic joint working and aid service improvement
- Continuing to advise upon and encourage implementation of Saving Babies Lives

It was a considered and deliberate decision for the Northern England Maternity Clinical Network to provide project support and clinical leadership to the two North East LMS, as well requesting the network groups to lead on specific workstreams. The Network is clinically led and very well established with the following groups bringing together multi-disciplinary, multi professional voices across organisational boundaries.

Maternity Network Groups:

Maternity Executive Group
The Maternity Executive Group is a leadership forum bringing together the 3 LMS SROs, Maternity Clinical Leads, Network staff and the Neonatal Network to shares updates from national and regional maternity transformation, update on STP/ICS governance and system change particularly as it relates to LMS, share LMS updates including progress and risk and review information and intelligence.

Maternity Clinical Advisory Group
The purpose of the group is to:

- provide advice and support to ensure the provision of the highest possible standard of safe, effective care to women and their babies/families,
- support the identification and reduction of unnecessary variation in outcomes
- share learning, best practice and innovation to optimise the quality and standardisation of care across provider organisations and individual clinicians within the Network.

- The network groups report into the Advisory Group

LMS: - This group also provides leadership and support to the LMS on multi-professional working, working across boundaries and postnatal care of the LMS transformation plan.

Perinatal Mental Health Network Clinical Advisory Group
The purpose of this group is to improve perinatal mental health care provision and access through:
- Pathway development ensuring that women who require mental health assessment or treatment get the right care at the right time and a higher number of women able to access specialist care
- To help in the development of new Perinatal Community Mental Health Teams and expansion of existing services.
- Workforce training needs assessment and delivery

LMS: Provides leadership and support for the Perinatal Mental Health section of the LMS transformation plan.

Heads of Midwifery Forum
To provide a professional forum for Heads of Midwifery and Senior Midwifery Leaders, from Provider Organisations to discuss, share best practice, learning and debate issues relating to Midwifery care and Safety across the North East and Cumbria patch.

LMS: Heads of Midwifery provide leadership and support for Continuity of Carer, Choice and Personalised Care Planning.

Maternal Medicine
Purpose of the group is to bring together health care professionals to discuss appropriate management of patients with complex medical problems during pregnancy; to share good practice, review evidence base, standardise guidelines, and agree regional referral pathways.

LMS: the group can advise LMS, CCGs/Specialised Commissioning on service standards and commissioning of services.

Fetal Medicine
Fetal Medicine services provide patient focused high quality evidence-based care to women with complex pregnancies or whose fetus(es) has a confirmed or suspected disorder.
The aim of the group is to bring health care professionals together to:
- discuss the management of the fetus(es) with complex problems during pregnancy;
- to share good practice, review evidence base, standardise guidelines, and agree regional referral pathways as appropriate with a key focus on quality and equity of access to service provision for those women who need it.

The group will discuss and make recommendations to the Maternity Clinical Advisory Group regarding safe and equitable regional pathways based on nationally recognised guidance, quality standards and outcomes framework.

LMS: The group will advise LMS, CCGs / Specialist Commissioning with regards to the commissioning of services for fetal disorders and/or abnormalities including fetal growth and wellbeing.

Maternity Patient Safety Learning Network
A forum for:
- Standardising and enhancing investigations of adverse incidents and ensuring system-wide shared learning.
- Providing external reviewers to root cause analysis and serious incident case reviews.
- Working with the AHSN to help co-ordinate across the region the QI activities as part of the Maternal and Neonatal Health Safety Collaborative.

LMS: provides leadership for the safety aspect of each LMS plan.

Joint collaboration with Northern Neonatal Network
The Neonatal Network have a joint programme of work with the three Local Maternity Systems including supporting implementation of the national ATAIN programme Avoiding Term Admissions Into Neonatal units e.g.:

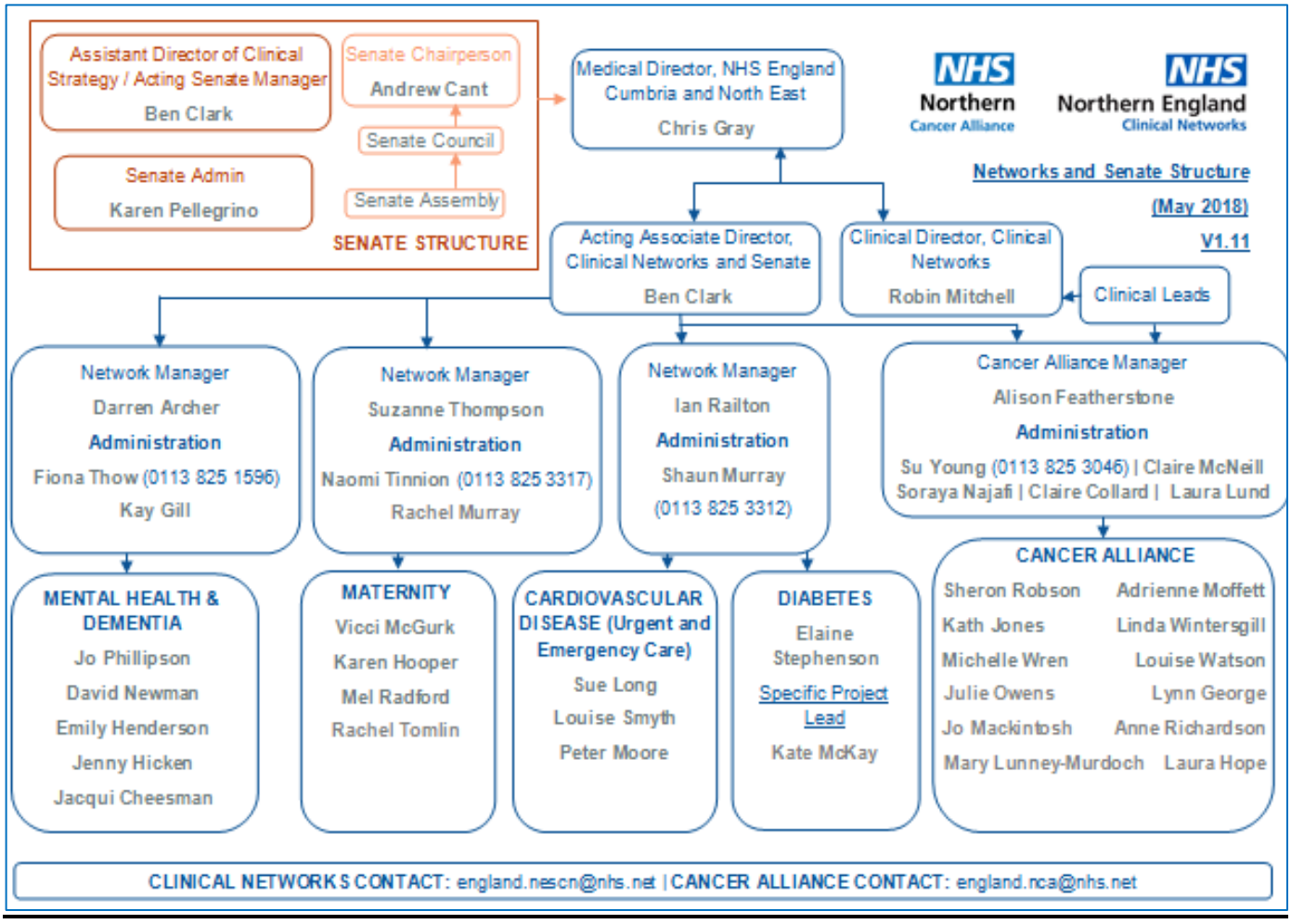
- Highlighting reported uptake of Magnesium sulphate & antenatal steroids in preterm deliveries
- Quarterly detailed LMS Data Reports, including focus on variation in term admission rates across neonatal units
- Quarterly meetings focussing on case review discussions and sharing learning outcomes from local neonatal death review meetings

LMS: provides leadership for the Neonatal section of the LMS plan

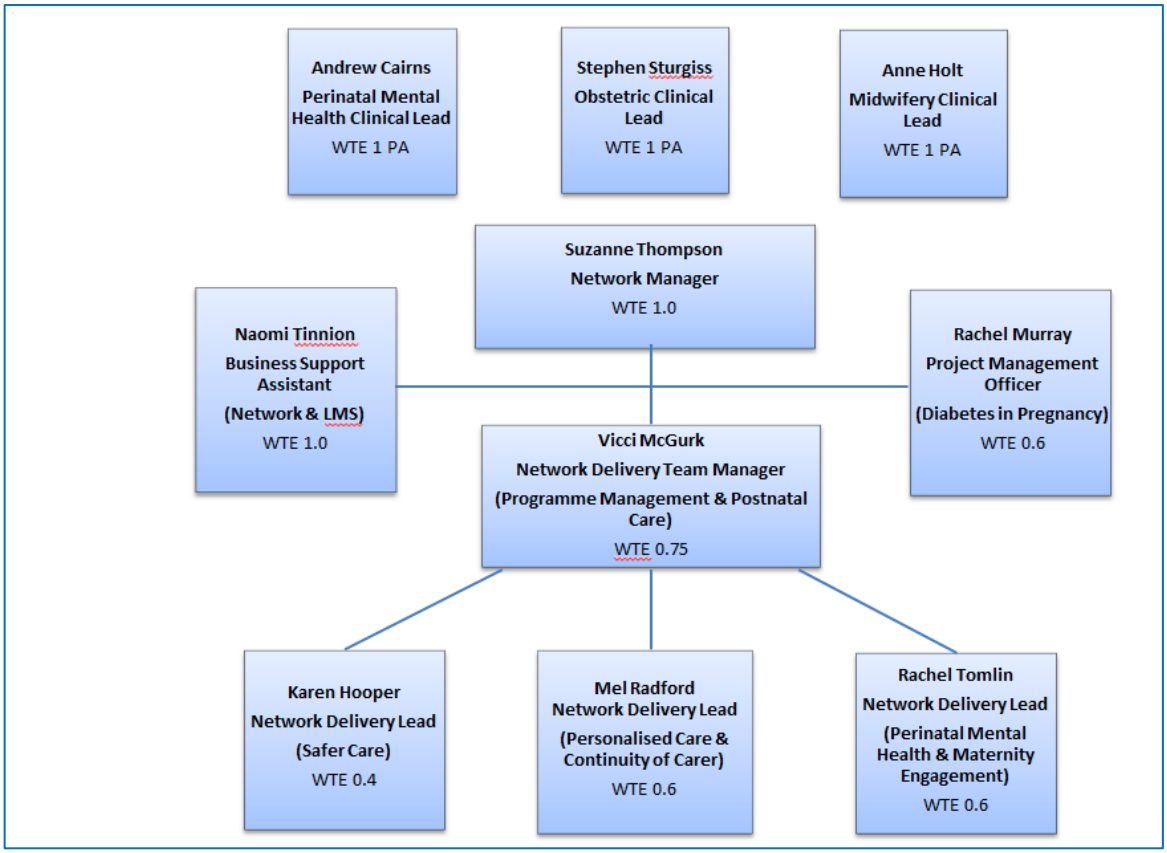
Prevention
The prevention workstream lead, Gill O'Neill, is a Consultant in Public Health at Durham County Council and NE Deputy Faculty Advisor. This role is supported by Wendy Burke, Director of Public Health at North Tyneside Council, and the North East Association of Directors of Health and Public Health and Public Health England. It links into the prevention workstream of the STP

LMS: provides leadership for the Prevention section of the LMS plan

Network Governance



Network Team



Communication and Engagement Strategy

The Communications and Engagement Strategy aims to ensure the delivery of effective communications to a wide range of internal and external stakeholders across the North East Local Maternity Systems. Various communications practices will be adopted and developed to help raise awareness and promote the work of the Local Maternity Systems and encourage engagement and collaborative working with the healthcare community and to local Maternity Voice Partnership (MVP) groups. Communications activity will be regularly evaluated to build on progress and achieve the agreed objectives.

Aims

Successful implementation of the Communications and Engagement Strategy will:

- Build and maintain relationships with, and deliver consistent messages to, key partners, patients, the public, NHS organisations and stakeholders, to encourage and support ongoing engagement and shared leadership.
- Effectively position the Local Maternity Systems to local, regional and national audiences through appropriate and accessible channels.
- Enable Local Maternity Systems to highlight the importance and impact of its transformation work.
- Support the development of strong two-way communications both internally and externally to a large range of target audiences within the healthcare community, the NHS and other partner organisations/stakeholders.

Objectives

- Increase the awareness and visibility of the Local Maternity Systems within the healthcare community and wider internal and external audiences using a range of on-line and off-line communications channels.
- Proactively promote the vision of Better Births to transform Maternity Services and raise awareness and understanding of the work of Local Maternity Systems, including the need for change.
- Ensure staff, clinicians, and service users are informed about and involved in co-production opportunities
- To develop and strengthen relations at regional and national levels.
- Support learning and improvement across Local Maternity Systems.
- Engage stakeholders in the design and development of emergent key priorities.
- Work in conjunction with third sector organisations, patient and carer involvement forums and networks in any identified communications activities, utilising the Northern England Clinical Network Patient and Public Participation Strategy.

Communications Principles

- **Accessible and inclusive** – to all our audiences
- **Clear and concise** – allowing messages to be easily understood by all
- **Consistent and accountable** – in line with our vision, messages and purpose
- **Cost effective** – we will use insight from data, information and lessons learned to make the best use of resources
- **Flexible** – ensuring communications and engagement activity follows a variety of formats, tailored to and appropriate for each audience
- **Open, honest and transparent** – we will be clear from the start of the conversations what our plans are, what is and what isn't negotiable, the reasons why and ultimately, how decisions will be made
- **Proportionate** – ensuring communications and engagement activity is appropriate, taking into account the potential number of people affected by proposed changes
- **Targeted** – making sure we get messages to the right people and in the right way

- **Timely** – making sure people have enough time to respond and are kept updated on a regular basis
- **Two-way** – we will listen and respond accordingly, letting people know the outcome of all conversations.

Key Messages

A small number of key messages will form the basis for all communications and engagement activity.

- We are working together for better births
- We want staff and service users to help improve local maternity services
- We want to make sure all children in get the best possible start in life
- Every woman will have access to the care she needs, when and where she needs it
- Every woman will have personalised maternity care to suit her and her family's needs
- Every woman will have safe care, high quality care during pregnancy, birth and postnatally
- We want to improve the entire maternity experience for women, including better antenatal, intrapartum, post and perinatal mental health services
- We will work together across organisational boundaries to support choice, personalisation and access to specialist care when needed
- We will work together across professions to deliver safer care – e.g., communication and working between primary and community care, midwives and hospital obstetricians will be more joined up
- Any recommendations to change services that come as a result work will be subject to, and informed by, public consultation

Target Audiences

At all stages, we take an inclusive approach and remain cognisant of target audiences, stakeholders and partner organisations. The LMS has a number of stakeholders that it communicates with on a regular basis including, but not limited to:

- Academic Health Science Network, Research Networks, Intelligence and Informatics Network
- Board and governing body members from the Sustainability Transformation Partnership (STP)/Integrated Care System(ICS) provider and commissioner organisations
- Clinical Commissioning Groups (CCGs) and Specialist Commissioning
- Clinical Leads and health care professionals involved in maternity care – acute, primary and community care
- GPs, Practice Nurses, other primary care professionals
- Health Education England, Health Education NE, Education Providers
- Local Authorities
- NHS England DCO and regional teams
- NHS provider trusts
- Maternity Voices Partnerships/Parent Groups/Service Users
- North Region Maternity Transformation Board
- Northern Neonatal Operational Delivery Network
- Perinatal Mental Health Network and National PMH Transformation Team
- Public Health England
- Regional Project Management Office PMO
- Relevant professional bodies (Royal Colleges)
- Voluntary third sector organisations including SANDS, Health Watch, MIND, NCT, Happy Mums Foundation, Raindrops to Rainbows

Communication Methods

No single communications channel will be effective in reaching and engaging all our audiences, therefore it is important to recognise that each target audience requires tailored communications to address specific expectations and needs.

There are a variety of communications and engagement methods currently being used as a means of communicating with stakeholders and presenting relevant information in a timely and proactive way.

These include use of the Network website, Clinical Networks Subgroups and bespoke meetings/ task and finish groups, newsletters/e-bulletins, briefing papers, events, abstract submissions to targeted publications/national events/transformation hub, focus groups, online surveys and social media.

The Network Maternity Engagement Group connects all MVPs and the lay representatives within the group have embraced social media as a way of reaching a wide audience of women and parenting groups in real time. This is providing a baseline and setting out service user expectations to inform and shape maternity transformation planning and implementation.

Communication Activities
In order to enable the LMS to quickly demonstrate its value and impact to stakeholders, and taking into consideration the limited communications resources, communication activities have been separated into 'routine', 'on request', and 'requiring external support' tasks.

Activities that can be supported routinely

- Updating website - adding 'news' stories, amending page content, point of contact for technical issues
- Twitter - anything to be shared on social media or support for Tweeting at events
- Event planning support – provision of marketing materials, use of Slido for Q&A sessions, social media, creation of website event page
- Support for CRM contact database - including technical issues

Activities that can be carried out on request, or provision of advice and guidance
These ad hoc requests may be supported by the Network dependent on priority and timescale, and advice can be offered at any stage.

- Creation of documents, graphics, simple infographics or presentations, using appropriate branding
- Compilation of newsletters/e-bulletins using MailChimp
- Creation of new pages/sections of the website, any major changes to existing pages
- Attendance at events to provide on-the-day social media/Slido/PPV support

Activities that can be fulfilled through liaison with third parties or requiring external input
Include:

- Specialist comms advice such as media liaison
- Special requests e.g. filming at events, bespoke infographics
- Design and production of new promotional materials e.g. banners, brochures
- Further development of website or CRM requiring web developer support

Glossary of Terms

A	
AiP	Alcohol in Pregnancy
AHSN	Academic Health Science Network
ATAIN	Avoiding Term Admissions into Neonatal Units
B	
BMI	Body Mass Index
C	
CAG	Clinical Advisory Group
CCG	Clinical Commissioning Group
CCQI	College Centre for Quality Improvement
CDDFT	County Durham & Darlington Foundation Trust
CDOP	Child Death Overview Panel
CMO	Chief Medical Officer
CoC	Continuity of Carer
CQUIN	Commissioning for Quality and Information
CR	College Report
CTGs	Cardiotocographs
D	
DCO	Director of Commissioning Operations
DTHRW	Darlington, Tees, Hambleton, Richmondshire and Whitby
F	
FGR	Fetal Growth Restriction
FT	Foundation Trust
G	
GDM	Gestational Diabetes Mellitus
GNCR	Great North Care Record
GPs	General Practitioners
GROW	Gestation Related Optimal Weight
H	
HEE	Health Education England
HEI	Higher Education Institute
HOMs	Heads of Midwifery
HSIB	Healthcare Safety Investigation Branch
HV	Health Visitors
I	
IAPT	Improving Access to Psychological Therapies
IDDM	Insulin Dependent Diabetes Mellitus
IHV	Institute of Health Visitors
ITU	Intensive Treatment Unit
J	
JCUH	James Cook University Hospital
L	
LA	Local Authority
LMS	Local Maternity System

M	
MBRRACE	Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries
MCMDS	Maternity and Children's Minimum Dataset
MECC	Making Every Contact Count
MEG	Maternity Engagement Group
MLU	Midwifery Led Unit
MPSLN	Maternity Patient Safety Learning Network
MSW	Maternity Support Worker
MTP	Maternity Transformation Programme
MTPB	Maternity Transformation Programme Board
MVP	Maternity Voices Partnership
N	
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NMC	Nursing and Midwifery Council
NNN	Northern Neonatal Network
NSECH	Northumbria Specialist Emergency Care Hospital
NTW	Northumberland, Tyne and Wear
O	
ODN	Operational Delivery Network
P	
PCP	Personalised Care Plan
PHE	Public Health England
PMCB	Personalised Maternity Care Budget
PMH	Perinatal Mental Health
PSC	Patient Safety Collaborative
Q	
QS	Quality Standard
R	
RCA	Root Cause Analysis
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RFM	Reduced Fetal Movements
RRR	Rapid Resolution and Redress
RVI	Royal Victoria Infirmary
S	
SABINE	Saving Babies Lives in the North East
SATOD	Smoking At Time Of Delivery
SBAR	Situation, Background, Assessment, Recommendation
SGA	Small for Gestational Age
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Partnership
V	
VCS	Voluntary Community Sector