Local Maternity System Transformation Plan for Northumberland, Tyne and Wear and Durham and Darlington, Tees, Hambleton and Richmondshire and Whitby

This plan sets out how the Local Maternity Systems (LMS) will deliver Better Births by the end of 2020/21.

LMSs brings together providers and commissioners to 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 as a system to implement it.

The plan and underpinning actions, once agreed by stakeholders, will be shared more widely. Key messages and updates will be communicated to key stakeholders and the public via the LMS, Northern England Clinical Network, STP and other LMS stakeholder communication mechanisms.

The plan will be delivered, monitored, assured and evaluated by the LMS Governance Process.
This is an overarching plan, progress and risks from network groups will be fed via Clinical Advisory Group (CAG) and highlighted to the LMS Board, any other workstream progress and risks will be directly reported to the LMS Board.
The Local Maternity System Boards would welcome your feedback at ***england.northernmaternity@nhs.net***

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Key:	Nationally led objective
	Regionally led objective

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.							
	Aim (Better Births Recommendation)	**Objectives**	**Planned Activity**	**Measure / Success Criteria (A clear statement from both a service and service user perspective on how services will be different once the plan is implemented)**	**Milestone Timescale**	**Lead**	**Interdependencies with other work streams**
1	Every woman should develop a personalised care plan, with her midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses.	Support implementation of personalised care plans for all women, using learning from pioneer sites to produce a locally agreed template and process.	1.1 Review outputs from National Pioneers.	Learning from National Pioneers identified and disseminated.	Ongoing	Mel Radford	Workstream 3 Choice and Personalisation
			1.2 Define Personalised Care Plan and describe how it should be developed throughout all parts of pregnancy journey (antenatal, intrapartum and postnatal) and review of current paperwork.	Definition of personalised care planning and what a woman's maternity care plan should record and how it is developed.	Mar-18	Vicci McGurk	Maternity Transformation Programme
			1.3 Baseline assessment of current Trust personalised care plan templates and review against the recommendations of what a woman's personalised maternity care plan should record.	Baseline position.	Jun-18	Mel Radford	Heads of Midwifery Forum
			1.4 Produce a standardised template for personalised care planning based on national recommendations and local examples of good practice.	Women enabled to make informed choices, informed by robust and comprehensive clinical advice that clearly states the risks associated with each choice. Each woman should have a personalised understanding of the risks that apply to her pregnancy and be able to make decisions about her plan B.	Jul-18	Mel Radford	Heads of Midwifery Forum Maternity Engagement Group
			1.5 Development of a checklist for a good antenatal choice discussion and a reminder of the questions to consider whilst the plan is being drawn up. Documentation to evidence antenatal choice discussion.	Women have the opportunity to discuss and voice their own care preferences. Personalised care plans will be centred on women's needs and decisions as well as being based on the offer of safe, effective and clinically appropriate care.	Jul-18	Mel Radford	Maternity Engagement Group
	Unbiased information should be made available to all women to help them make their decisions and develop their care plan. This should be through their own digital maternity tool, which enables them to access their own health records and information that is appropriate to them, including the latest evidence and what services are available locally.	Creation and provision of unbiased and standardised information for pregnant woman and their families	1.6 Develop a baseline of information (what, how and when is information disseminated) that is currently provided and in what format to women and their families and review outputs from National Pioneers.	Baseline position with local and national examples of good practice highlighted.	May-18	Mel Radford	Maternity Engagement Group
			1.7 Provide recommendations and guidance for providing contemporary, consistent unbiased information and professional advocacy for women.	Birth decision aids and support for choosing your place of birth developed. PMA to midwife ratio mapped and implementation of A-EQUIP model assessed.	Jun-18	Mel Radford	Maternity Engagement Group
			1.8 Scope existing technology nationally and locally which could support implementation of a digital maternity tool, linking in with STP Digital Leads.	Business case for technology development including financial impact.		Suzanne Thompson	Workstream 7 Harnessing Technology Workstream 6 Data and Information NHS Digital Great North Care Record
			1.9 Review training programmes for midwives and student midwives at HEI and Trust level to promote effective communication around shared decision making.	Learning opportunities identified at mandatory training, public health, mentorship updates. Training needs analysis.	Aug-18	Mel Radford	Higher Education Institutes, Provider Trusts
	Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.	Scope place of birth options within LMS to provide information to help woman make informed choices, taking into account individual needs.	1.10 Honest and accurate baseline assessment (eg "Do we provide the type of personalised care planning envisaged in Better Births?") which is based on service users' understanding of services (eg "Do women feel they are offered choice?" rather than "Do we offer choice?"). This will require qualitative and quantitative data on service user experience. Review/incorporate post-PCP perceptions of where the care plans listened to? Need to take into account involvement of key supporters of women throughout their childbirth journey.	Service user survey Baseline of what birth choice options are available for the Local Maternity System footprint	Apr-18	Mel Radford Rachel Murray	Maternity Engagement Group WHICH Trust Information Leads
			1.11 Define low risk settings.	Cross boundary agreement of low risk definition – include information about units with dedicated low risk areas and home birth provision.	Jul-18	Vicky Arnott	Heads of Midwifery Forum MPSLN
			1.12 Supporting Personalised Care Through the Development of New Roles – Pilot of the Baby Support Worker in the Community Setting (dependent upon finding funding).	• Trial a new role within the community midwifery setting that has already been successfully introduced into the hospital setting and has been demonstrated to improve outcomes for babies. • Provide an opportunity to pilot skill mixing within community midwifery teams that could facilitate a more flexible workforce and the introduction of continuity of carer. • Provide an option for an enhanced postnatal offer for vulnerable babies and their parents. • Reduce the number of neonatal readmissions to hospital during the postnatal period. • Reduce length of stay for babies requiring transitional care whilst facilitating a safe discharge. • Improved breastfeeding initiation and duration rates particularly amongst vulnerable babies. • Improved patient experience outcomes for parents. • Contribute to the prevention 'must do's' including smoking cessation, substance misuse, mental health, supporting healthy eating and weight reduction and vaccination targets.	Mar-19	Anne Holt	Workstream 3 Choice and Personalisation Postnatal Care Neonatal Care Prevention Workforce Transformation Mental Health in the Perinatal Period County Durham and Darlington Foundation Trust Local Maternity System Board
			1.13 Clear process to link to other specialist care pathways - e.g. Specialist clinical needs, mental health pathways, primary care needs, social care needs.	Define specific groups of woman for which targeted care pathways need to be further developed e.g. Twin pregnancies/raised BMI and support implementation.	Dec-18	Karen Hooper	Maternal Medicine Group

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			1.14 Develop a region-wide response to Hidden Voices recommendations. Large mapping/engagement event took place Feb 2017 to scope what currently exists for women with learning disabilities when using maternity services and identify any gaps and opportunities. A Steering Group was established to develop a work programme and lead delivery of improvements.	• Create reasonably adjusted maternity care pathways for women with learning disabilities (antenatal, during labour and postnatal). • Develop and implement a 'maternity chapter' of a learning disability hospital passport. • Pilot the effectiveness of the Change maternity resources across Cumbria and North East on behalf of the Maternity and Women's Health Policy Team, NHSE and identify gaps in easy read resources including: a resource for GPs to give to newly confirmed expectant mothers telling them they are pregnant and what will happen next, 'Measure the bump' resource and 'Sweep' resource • Develop ideas to make sure the maternity workforce have the right skills, knowledge and competence to support women with learning disabilities.	Mar-19	Judith Thompson	Learning Disability Network Geordie Mums Heads of Midwifery Forum Maternity Clinical Network CHANGE
			1.15 Piloting the development of digital personalised care plans	The Badger portal will be opened to a select test group of mothers from the 11th June. It will also be trialled with vulnerable groups such as learning difficulties/disabilities and the young women's project in Gateshead. It will open up access to antenatal and postnatal records. Friends and family questions will be on this with access to National and local leaflets including the newly developed LMS choice booklet. Staff and user training provided.		Lesley Heelbeck	NHS Digital Workstream
			1.16 Consider single point of access for the booking of pregnant women whilst understanding what is within our ability to create. Consider developing app/ 24/7 programme directing women and families to regional options/choices that may be available.	Learning from early adopters.	Commence upon agreement of models of care	LMS Midwifery Leads	Workstream 3 Choice and Personalisation
This is an overarching plan, progress and risks from network grou	Women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget.	Engage and learn from pilot sites particularly those that reflect our local demographic.	1.17 Monitor outputs from the national team, and review any information about PMCBs within the relevant network / LMS groups as soon as they become available.	Monitor outputs from the National team and provide updates to network groups.	As available	NHS England National Team	

Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.							
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2	Every woman should have a midwife, who is part of a small team of 4-6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy birth and postnatally.	Localise models of Continuity of Carer to deliver national recommendations	2.1 Define 'Continuity of carer'	Definition agreed for continuity of carer in north region.	Complete	Suzanne Thompson	North Region Maternity Transformation Board
			2.2 Literature review of the UK and international evidence base.	Review and critique of evidence on Continuity of Carer.	Complete	Mel Radford	
			2.3 Review outputs/learning from early adopters.	Learning identified to inform future planning.	Ongoing	Mel Radford	Early Adopters
			2.4 Establish the baseline position and set trajectories.	Understanding of current position and level of ambition.	Complete	Suzanne Thompson	
			2.5 Scope costings of small team midwifery	Transferable learning shared.	May-18	Sheila Ford	
			2.6 Identify cohorts of women suitable for early implementation based on evidence base highlighting significant improvements in outcomes.	Localised agreement of targeted cohorts.	May-18	Mel Radford	
			2.7 Baseline perception of continuity of care (workforce and service users) within existing care provision	Carry out a survey on the perception of continuity of care within existing care provision by a workforce survey and identify ideas to shape the development of pilots and individuals to take part in shaping the work.	Jul-18	Jenny Hicken	Maternity Engagement Group
			2.8 LMS combined bid for Continuity of Carer model. Team model incorporating Consultant Obstetrician, Specialist Midwife, Midwives and Maternity Support Workers within the team members. Targeting identified cohorts of women: Gestational Diabetes (GDM) / Diabetes (IDDM), high risk pregnancies and vulnerable women including learning disabilities.	• An established cohort of patients that receive continuity of carer. • 20% of women on Continuity of Carer pathway. • Improved management of diabetes. • Improved management of obesity during pregnancy • Increased rate of contraception uptake post birth • Increase father and family engagement • Increased breast feeding rates • Improved clinical outcomes for both mothers and babies. • Proof of concept for continuity of carer for both women and families, midwives and the MDT with a view to extending this further.	Mar-19	Heads of Midwifery LMS Midwifery Leads	Local Maternity System Boards Maternity Engagement Group NHS England Maternity CAG
			2.9 Trust level pilots designed to meet 20% Continuity of Carer target.	Preparation work to determine alternative CoC models regionally prior to focus group / survey feedback. All units undertaking the high dependency diabetic model. **North Tees** Explore 1 community team, which includes 1 x band 7, 6/7 band 6, MSW in the team. Team midwifery model of care. **South Tyneside** By April 2019 explore free standing midwifery led unit/ community hub. Core MLU team. Integrated core MLU aligned to a community team. Team midwifery model of care. **South Tees** Explore the options for alternative maternal medicine women linking with the diabetic high dependency model. Friarage Maternity centre explore team CoC concept **Newcastle** Explore the options for alternative maternal medicine women linking with the diabetic high dependency model. **Northumbria** Alnwick free standing MLU, Berwick free standing MLU: explore providing continuity of carer model within the current structure. Team midwifery model Hexham free standing MLU: explore providing continuity of carer team midwifery model NSECH implement the diabetic high dependency model. Scoping other initiatives for example home birth team model **Gateshead** Explore the options for alternative maternal medicine women linking with the diabetic high dependency model. **Durham/Darlington** Explore potential for team or caseloading within Community Hubs. Potential sites at three locations. Explore the options for alternative maternal medicine women linking with the diabetic high dependency model. **Sunderland** Explore the options for alternative maternal medicine women linking with the diabetic high dependency model. Explore development of current model of care to expand upon what is currently available.	Mar-19	Heads of Midwifery LMS Midwifery Leads	Provider Trusts
			2.10 Agree models for implementation in co-production with MVPs, workforce and linking to Directors of Nursing to ensure feasibility of proposed models	Sustainable models of care agreed within local maternity systems.	Apr-19	Anne Holt Mel Radford	Local Maternity System Boards Maternity Engagement Group NHS England

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Each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate.	Produce directory for the region of obstetricians and their areas of interest.	2.11 Undertake a consultant obstetrician gap analysis and review of specialities and special interests.	Overview of obstetrician resource within local maternity systems	Jul-18	Mel Radford	
Community hubs should enable patients to access care in the community from their midwife and from a range of others services, particularly for antenatal and postnatal care.	Scope availability of community hubs involving the Local Authority/MVPs and other stakeholders.	2.12 Understand local needs and demands analysis within each Local Maternity System	Stakeholder mapping and engagement, deprivation and travel distance maps, mapping of existing provision, development of a community engagement plan. Report developed highlighting gaps and opportunities.	Oct-18	LMS Midwifery Leads Mel Radford	Workstream 1 - Local transformation Workstream 9 - Prevention Workstream 2 - Safer Care Workstream 4 - PMH Maternity Engagement Group GPs Health Visitors
	Collectively agree and model community hub designs.	2.14 Develop strategic objectives and key priorities.	The Badger portal will be opened to a select test group of mothers from the 11th June. It will also be trialled with vulnerable groups such as learning difficulties/disabilities and the young women's project in Gateshead. It will open up access to antenatal and postnatal records. Friends and family questions will be on this with access to National and local leaflets including the newly developed LMS choice booklet. Staff and user training provided.	Jan-19		
		2.15 Agree clinical models for hub design based on locally agreed context.	Co-produced models for community hub design agreed by STP.	Dec-19		
The woman's midwife should liaise closely with obstetric, neo-natal, and other services ensuring that they get the care they need and that it is joined up with the care they are receiving in the community.	Improve current pathways to ensure personalised care and clear handovers between professionals.	2.16 Identify training needs and existing local multi-professional training workshops/programmes.	Training need analysis and regional training provision mapped.	Aug-18	Mel Radford	
		2.17 Digital enabling work will include a review of arrangements in the community for off-site access to hospital IT systems and explore inter-operability links to existing systems such as GROW. Review use of existing telemedicine services to consider roll out across wider area (e.g. Florence, CTGs, scanning services).	Maternity Digital Maturity Assessment (DMA) process is underway and is due to complete at the end of June 2018.	Jan-19	Suzanne Thompson LMS Digital Leads	NHS Digital STP Digital Leads (STP and National)

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3	Provider boards should have a board level champion for maternity services. They should routinely monitor information about quality, including safety, and take any necessary action.	Identify all board level champions at each Trust and establish a communication channel.	3.1 LMS SRO to write to all trusts to request named board level champion.	Clarify who are the board level champions.	Jun-18	Julie Lane Andrew Beeby Eleanor Hodgson	
	Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services.	Boards and LMS supporting quality improvement work alongside The Maternal Neonatal Health Safety Collaborative.	3.2 Develop link with Academic Health Sciences Network and Wave 1 safety collaborative Trusts	Regular meetings with Maternal & Neonatal Collaborative	Complete	Karen Hooper	AHSN, Wave 1, 2 ,3 Trusts, Neonatal ODN, National Patient Safety Team, CAG, MPSLN
			3.3 Continue link to AHSN and Wave 2 safety collaborative Trusts	Regular meetings with Maternal & Neonatal Collaborative	Mar-18		
			3.4 Continue link to AHSN and Wave 3 safety collaborative Trusts	Regular meetings with Maternal & Neonatal Collaborative	Mar-19		
			3.5 Support sharing of good practice, lessons learnt and national feedback across all waves via MPSLN and network communications and report to LMS boards	Good practice shared from the collaboratives - quarterly learning community events/regular teleconference	Ongoing		
	There should be rapid referral protocols in place between professionals and across organisations to ensure that the woman and her baby can access more specialist care when they need it.	Standardise and implement specialist fetal and maternal medicine clinical guidelines including use of referral pathways.	3.6 Agree a list of specialised guidelines to produce regional version. Production of accompanying documentation to support implementation including auditable standards.	Create a list of specialised guidelines to agree and standardise.	Complete	Karen Hooper	Fetal / Maternal Medicine Groups, CAG, Provider Trusts, specialist advisors as required (e.g. Neurologists), Tertiary specialist centres
				Develop regional guidelines as per schedule and recommend regional adoption.	As per rolling programme		
	Teams should routinely collect data on the quality and outcomes of their services, measure their own performance and compare against others' so that they can improve.	Continue to develop the Northern England Clinical Network Maternity Dashboard designed to reflect a common agreement and understanding of safe care.	3.7 Quarterly Trust data submission - creation of dashboard infographic and display posters to enable benchmarking and service improvement.	Regular reports developed for CAG to inform provider Trusts on the outputs from the Regional Maternity Dashboard.	Ongoing	Rachel Murray	Maternity CAG, link with National Dashboard including the Neonatal Indicators, regional data team, Public Health England, AHSN
		Monitor reports from National Audit Programmes (MBRRACE, Each Baby Counts) to identify outliers and sources of good practice and share quality improvement ideas.	3.8 Receive national reports as published, attend report launches as appropriate and share learning.	Disseminate national reports to provider Trusts as available - use to inform future Quality Improvement initiatives. Highlight issues for action via MPSLN & CAG	Ongoing as reports are published	Karen Hooper/Rachel Murray	MBRRACE, Each Baby Counts
	Data collection should be refocused on the most useful information so as to minimise the burden on women and their professionals. A nationally agreed set of indicators should be developed to help local maternity systems track, benchmark and improve the quality of maternity services.	Alignment with national indicators	3.9 Implement nationally agreed set of indicators as available.	All provider Trusts submit required data to nationally agreed indicators	Ongoing	Rachel Murray	National development of indicators, NHS Digital, provider Trusts, CAG
		Identify audits currently in progress across provider Trusts to identify variation and standardise key audit priorities	3.10 Baseline assessment of Trust audits.	Provide summary report of unit submissions information around audits including inter-unit variations.	Complete	Karen Hooper	MPSLN, provider Trusts, national audits, CAG
			3.11 Identify and standardise 10 key audits for regional undertaking.	10 agreed audits with proformas to be developed	Dec-18	Karen Hooper	MPSLN, CAG, HOMs
		Support all Trusts to implement reporting to the Rapid Redress Resolution Scheme.	3.12 Share Trust process for implementing reporting, feed back learning as appropriate.	All Trusts have a clear reporting process. Report from scheme shared with all Trusts (Cerebral palsy paper). RRR team presenting at Patient Safety event (22/5/18)	Complete	Karen Hooper	MPSLN, NHS Resolution
	Continue to build on and develop Saving Babies Lives Project. Sustaining the improvements already made by the SABINE (Saving Babies Lives in the North East) Project.	Element 1 - Reducing Smoking in Pregnancy - work alongside PHE to highlight commissioning requirements for Stop Smoking Services	3.13 Linking with Public Health England, map out current practice across the region in relation to provision of Stop Smoking Services (SSS) and raise importance of commissioning for effective services.	Regional benchmarking exercise completed	Complete	LA Public Health, Allison Metters, Alisa Rutter, Ruth Bell, Gill O'Neill	MPSLN, Prevention, CAG, HOMs, provider Trusts, smoking cessation services, voluntary services (e.g.. FRESH)
			3.14 Support implementation of standard SSS protocols and brief interventions.	The Badger portal will be opened to a select test group of mothers from the 11th June. It will also be trialled with vulnerable groups such as learning difficulties/disabilities and the young women's project in Gateshead. It will open up access to antenatal and postnatal records. Friends and family questions will be on this with access to National and local leaflets including the newly developed LMS choice booklet. Staff and user training provided.	Ongoing		
			3.15 Undertake workforce review and training needs analysis to support effective use of Maternity Support Workers and others to provide SSS support.	Workforce and training analysis conducted.	Apr-18		
		Element 2 - Detecting Fetal Growth Restriction (FGR)	3.16 Review guidelines and pathways for identification and management of pregnancies at risk of FGR.	Regional SGA guideline with recommendation to implement	Jun-18	Therese Hanon, Karen Hooper	Fetal medicine group, CAG, AHSN
			3.17 Support all Trusts to input birth weight centiles into GROW programme.	Increased number of Trusts recording birth weight centile onto GROW	Apr-18	Karen Hooper	HOMs, MPSLN, Provider Trusts, perinatal institute

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		Support Trusts to fully implement the GROW programme including consideration of funding from LMS to provide backfill for clinical project leads within acute providers and development of guidelines for the detection and management of growth restricted pregnancies	3.18 Support all Trusts to complete audits of missed cases to identify areas for improvement and themes. Share lessons learnt and good practice via MPSLN, network communications and regional safety events.	Full submission to quarterly Saving Babies Lives audit	Apr-18 Ongoing	Karen Hooper/Rachel Murray	MPSLN, Perinatal Institute
			3.19 Support Trusts to utilise GROW staff training	CDDFT supported by LMS funding to provide GROW study day	Jun-18	LMS SROs	Provider Trusts, perinatal institute, HOMs
		Element 3 - Raising Awareness of Reduced Fetal Movement - work with all stakeholders to promote awareness of fetal movements with women and their families. Encourage use of pathways to risk assess and manage reduce fetal movements	3.20 Review use of pathways and guidelines across the region - develop agreed tool for management of RFMs	Regional approach to management of RFMs	Sep-18	Karen Hooper	MPSLN, provider Trusts
			3.21 Review all possible channels of communication to raise importance of RFMs amongst public	Coordinated approach to ensure all pregnant women receive consistent advice around RFMs	Sep-18	Rachel Tomlin	Maternity Engagement Group, HOMs
		Element 4 - Improving Effective Fetal Monitoring During Labour - develop shared fetal monitoring guidelines	3.22 Retain awareness of regional issues with fetal monitoring via MPSLN, case reviews and thematic reviews		May-18	Karen Hooper	MPSLN
	There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.	Regional standardisation of investigation processes to be agreed and implemented in line with National Guidance.	3.23 Develop terms of reference for ensuring externality at identified case reviews, link to National examples of incorporating externality into RCA process including development of role description, terms of reference	Terms of Reference developed and approved by LMS Boards	May-18	Karen Hooper	MPSLN, LMS boards, provider trusts, HOMs, HSIB, MBBRACE-UK, NHS Digital
			3.24 Share lessons learnt from serious and other case reviews across the region and support service improvement projects based on these lessons learnt	Share lessons learnt from serious case and other case reviews via patient safety learning events and bulletins	Ongoing		
		Perinatal mortality review tool. Support implementation in all Trusts	3.25 Feedback Intelligence from National Team.	Feedback shared from the National Perinatal Mortality Review Tool	As available	Karen Hooper	MPSLN, MBRRACE-UK, provider trusts
			3.26 Support Trusts in implementing tools when available.	Trusts implement Perinatal Mortality Review Tools	Jan-18		
		Agree incident reporting trigger lists and standardised templates for reviews of common incidents.	3.27 Agree a minimum standardised list of obstetric risk management incidents.	Standardised incident reporting trigger list	Complete	Karen Hooper	MPSLN
			3.28 Develop and implement standardised proformas for the review of common incidents.	Standardised templates for review of common incidents.	Complete		
			3.29 Agree types of incidents that will need RCA with external input.	RCA Terms of reference & process	Jun-18		
			3.30 Identify themes and review further to share good practice and improvement actions.	Regional patient safety event, regular lesson learnt bulletins	Ongoing		
	There is already an expectation of openness and honesty between professionals and the family, which should be supported by a system of rapid resolution and redress, encouraging learning and ensuring that families quickly receive the help they need.	Support implementation of National Guidance.					

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.							
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4	There should be significant investment in perinatal mental health services in the community and in specialist care, as recommended by NHS England's independent Mental Health Taskforce.	Early identification of screening and assessment of perinatal mental health during pregnancy and babies first year.	4.1 Ensure there is consistency in what questions are asked at the booking appointment and subsequent appointments regarding mental well-being.	More women with mental health issues identified early on.	Jul-18	Rachel Tomlin Mel Radford Andrew Cairns	Continuity of Carer
			4.2 Ensure perinatal mental health is considered in the development of community hubs.	Access to mental health services close to home when needed.	Jul-18		
		Embed and implement the perinatal mental health pathway across the network.	4.3 Map out existing services to look at what exists and works well.	Develop a baseline from which to work on.	Complete	Alison Johnson	
			4.4 Identify the gaps in current service provision i.e. around secondary care.	Identification of gaps in current service to help with bid writing and future service development.	Jul-18	Andrew Cairns Rachel Tomlin	LMS Boards HOMs
			4.5 Check that services are inclusive of those who are vulnerable or with particular needs e.g. those with learning disabilities.	High quality care for all.	Jul-18	Rachel Tomlin Andrew Cairns	Learning Disabilities Network
			4.6 Build the Perinatal Mental Health pathway into the personalised care plan therefore embedding the pathway to ensure all staff know who to refer on to at every step of the pathway.	Smoother care for all our women building choice into the personalised care plan.	Dec-18	Andrew Cairns Rachel Tomlin	Personalised Care Planning
			4.7 IAPT - measure against mapping report 2017. Share recommendations such as fast-track for PMH to be 6 weeks.	Equitable service for all our mild to moderate mums.	Dec-18	Jacqui Cheesman	
			4.8 Dedicated Mental Health Obstetric Clinics in each Trust.	Women with severe affective disorders can be seen in a timely manner close to home.			
			4.9 Establish perinatal mental health Champions across Primary and Secondary care in Community Hubs, maternity and mental health services.	Champions at each stage of the pathway will ensure staff always have a point of contact to discuss care co-ordination.	Mar-19	Andrew Cairns Rachel Tomlin	
		Support the ongoing implementation of local evidence based specialist community perinatal mental health teams who are receiving funding in wave 1 and 2 of the PMH community services development fund.	4.10 Learn from wave 1 community development funded services. Bid successful and Newcastle and North Tyneside service expanded across Northumberland and Gateshead. New accommodation acquired and new members of staff. Will roll out across Sunderland and South Tyneside next.	More women can access specialist (secondary care) perinatal mental health care services across NTW.	Jul-17	Andrew Cairns Jan Rigby	
			4.11 Support Trusts bidding for wave 2 funding. Offer support with bid writing and experience from wave 1 bidding process.	Two bids submitted from North West Cumbria and DTHRW STP.	Mar-18	Andrew Cairns Rachel Tomlin	
			4.12 Support all areas to develop strategic plans for ongoing sustained funding and development of evidence based specialist community perinatal mental health teams in preparation for national PMH funding reaching CCG baselines in 2019/20.	Community perinatal mental health services available to all across the LMS.	Mar-21	Andrew Cairns Rachel Tomlin	Trusts CCGs
			4.13 Host and facilitate multi-professional Perinatal Mental Health meetings and events to reduce variation, showcase good practice, spread innovation and learning. Conference to raise awareness of perinatal mental health service need.	Conference arranged for June 2018 to raise awareness of perinatal mental health. Encourage Commissioner engagement. Embedding of the pathway. Next steps identified.	Jun-18	Andrew Cairns Rachel Tomlin Fiona Thow	
			4.14 Measure Perinatal Mental Health services against RCP CCQI CR197 standards and NICE QS115 to establish baseline and identify gaps. Develop action plan, implement and evaluate. Advocate 2 week target to assessment and 4 hour target for assessment of suspected Puerperal Psychosis.	High quality commissioning of services.	Dec-18	Andrew Cairns Rachel Tomlin	
			4.15 Ensure that robust mechanisms are in place for enabling families to be actively involved in the ongoing development of local PMH services, and regional and local decision making.	Close links with the Maternity Engagement Group. Services developed with the user at the centre particularly around mapping of preferences eg location / access.	Mar-19	Rachel Tomlin	Maternity Engagement Group
			4.16 Include the use of telehealth and other innovative opportunities.	Follow up / review appointments to be done this way to save travel time.	Sep-19	Andrew Cairns Rachel Tomlin	NHS Digital
			4.17 Create a champions web and directory of 3rd sector organisations such as Happy Mums, Nest, Raindrops to Rainbows etc.	Clear signposting for staff and mums, dads/partners and family members to additional support in the community.	Sep-19	Andrew Cairns Rachel Tomlin	Happy Mums, Nest, Raindrops to Rainbows
			4.18 Working in coproduction with women and families with experience in developing new services and reviewing existing services.	High quality services with the woman, baby and family at the heart of the service. Designed by women for women.	Sep-19	Andrew Cairns Rachel Tomlin	Happy Mums, Nest, Raindrops to Rainbows
			4.19 Support quality improvement and outcome measurement in specialist perinatal mental health services - including supporting the sharing of data on access and outcomes to enable benchmarking of local services.	Annual audit to demonstrate areas of improvement.	Mar-21	Andrew Cairns Rachel Tomlin	Trusts CCGs
		Training - Develop a regional PMH training and workforce development strategy in line with the Health Education England	4.20 Review what training is currently delivered across the network.	Report published July 2017.	Complete	Caroline Machray	AHSN

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.						
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	competency framework.	4.21 Task and Finish group established to look at training needs.	Action plan developed to address training needs for everyone involved in the pregnancy pathway.	Dec-17	Andrew Cairns Rachel Tomlin	HEE
		4.22 Awareness training to GPs via time in / time out sessions.	Raised awareness of perinatal mental health in primary care with the focus on red flags and where to refer.	Dec-18	Andrew Cairns Natalie Smith Rachel Tomlin	CCGs
		4.23 Prevention money to fund 24 places for train the trainer iHV training across the network.	Each Trust and Local Authority will have someone trained in perinatal mental health who can deliver high quality training to staff in house, working as a team.	Dec-18	Gill O'Neill Andrew Cairns Rachel Tomlin	HOMs
		4.24 Mandatory training for all our midwives and obstetricians - identified in the PMH training report: * access on-line training packages (HEE). * iHV refresher training for HV.	All staff trained to a high standard and able to identify and refer a mum on in a timely fashion.	Mar-19	Andrew Cairns Rachel Tomlin	HEE e-learning advertise Universities iHv
		4.25 Specialist Services regional training sessions.	Highly trained specialist team.	Jun-19		
		4.26 Annual refresher training for Liaison team and Crisis Teams.	Highly trained team.	Jun-19		
		4.27 PMH Training needs to be embedded nationally at every step of the pathway. There is currently very little routine PMH training for staff. Needs to be a national drive to rectify this.	A nationally recognised and accessible training programme for all staff.	Dec-19	Andrew Cairns Rachel Tomlin	National Perinatal Mental Health Network HEE
		4.28 Support the dissemination and implementation of national guidance, local tools and resources to improve PMH services across the pathway - including embedding the perinatal mental health competency framework.	Ensuring that services are evidence based and of the highest quality with highly trained staff within them.	Dec-19	Andrew Cairns Rachel Tomlin	National Perinatal Mental Health Network HEE
		4.29 Continue to support the development of local workforce plans - assisting STPs/CCGs to understand their workforce requirements (number/skill mix) to deliver comprehensive specialist perinatal mental health services in line with national guidance.	A full complement of staff.	Dec-19	Andrew Cairns Rachel Tomlin	National Perinatal Mental Health Network HEE
Postnatal care must be resourced appropriately. Women should have access to their midwife (and where appropriate obstetrician) as they require after having had their baby. Those requiring longer care should have appropriate provision and follow up in designated clinics.	Review current postnatal care and create a minimum schedule of postnatal care incorporating NICE recommendations and support roll out across the region.	4.30 Work with local service users to identify service user expectations for postnatal care - survey / focus groups.	Service user baseline.	Jul-18	Anne Holt Vicci McGurk	Maternity Engagement Group
		4.31 Baseline assessment / scoping exercise with NHS maternity services, health visitors and GPs, mapping the roles currently played by each and identifying opportunities for and barriers to improving postnatal care.	Professional baseline.	Jul-18	Anne Holt Vicci McGurk	iHv GPs, Provider Trusts
		4.32 Review NICE guidance on postnatal care and carry out a gap analysis against Trust policies to assure compliance and identify areas of non-compliance.		Jul-18	Anne Holt Vicci McGurk	Heads of Midwifery
		4.33 Ensure postnatal care is included within PCPs and is standardised information.			Mel Radford	Personalised Care Planning
		4.34 Consider approaches for how the Local Maternity Systems might improve postnatal care. Areas of interest might include breastfeeding, perinatal mental health, stopping smoking and postpartum contraception.			Anne Holt Vicci McGurk Gill O'Neill	Prevention
		4.35 Review workforce skill set to develop Maternity Support Workers/community teams to have provision for extended visits when necessary.			Anne Holt Vicci McGurk	
		4.36 Consider the role the voluntary and community sector and independent midwifery practices can play in improving quality and capacity in postnatal care.		Dec-18	Anne Holt Vicci McGurk	
Maternity services should ensure smooth transition between midwife, obstetric and neonatal care and ongoing care in the community from their GP and health visitor.	Improve transition between maternity services and the health visiting team, in particular by including the handover in the personalised care plan.	4.37 Develop documentation and a system that supports transition of care between professionals.	Identify handovers throughout the pathway and recommend documentation includes SBAR tool to minimise repetition of questions and ensure seamless handover of information between care settings and providers.	Sep-18	Anne Holt Vicci McGurk	Primary Care Leads Health Visitors CCGs and Providers PMH Network CAG Community Hub Development

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.						
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		4.38 Review the provision of bereavement support to women and their families when a baby dies during pregnancy or whilst receiving specialist support through neonatal intensive care units.	Local Maternity Systems to consider the following in particular: ● Specialist training available to staff. ● Availability of specialist bereavement midwives. ● Availability of bereavement rooms and facilities to enable women and their families to spend time with their baby. ● Links to funeral directors. ● Links to national charities, local support groups and bereavement counselling services.	Jun-18	Anne Holt Vicci McGurk	SANDS, Local Maternity System Boards
A dedicated review of neonatal services should be taken forward in light of the findings of this review.		4.39 Consider findings of neonatal review and support implementation of actions.		As per Neonatal timescales		Safer Care Neonatal Operational Delivery Network NHS England Maternity CAG

Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.							
	Aim (Better Births Recommendation)	**Objectives**	**Planned Activity**	**Measure / Success Criteria (A clear statement from both a service and service user perspective on how services will be different once the plan is implemented)**	**Milestone Timescale**	**Lead**	**Interdependencies with other work streams**
5	Those who work together should train together. Multi-professional learning should be a core part of all pre-registration training for midwives and obstetricians, so that they understand and respect each other's skills and perspectives.	Strengthen culture of working together	5.1 Review complete. NMC and RCOG to include in their education.		Ongoing	National	NMC, RCOG.
	Multi-professional training should be a standard part of continuous professional development, both in routine situations and in emergencies.	Strong culture of respect across professions and sharing of knowledge and insight.	5.2 Agree and prioritise the training that should be multi-professional and part of continuous development.	Develop a report with recommendations for future training and how this could be achieved.	Sep-18	Stephen Sturgiss	CAG
			5.3 Oversee progress in delivering the training.	Evidence of multi-professional training being undertaken.	Annually	Stephen Sturgiss	HEE
	To support sharing of data and information between professionals and organisations. Use of an electronic maternity record should be rolled out nationally. Providers should ensure the woman shares and can input information that is important to her.	Support the development of digital personalised care plans	5.4 Identify and appraise the maternity apps/ IT options currently available to determine if they are fit for purpose and how they will fit with the wider digital strategies and plans across the STP areas and nationally.	Recommendations for the development of business cases.	Dec-18	TBC	HOMs, LMS Digital Leads, STP Digital Workstream (and national)
			5.5 Share and discuss this appraisal with all relevant providers of maternity care in the area. Support development of appropriate business cases.				STP and national Digital Workstream
		Harmonise IT systems and/or introduce mechanisms for inter-operability.	5.6 Establish links with the team leading on the development of the Great North Care Record.	Link to the development of Great North Care Record through the Digital Programme Care Board.	Ongoing	Suzanne Thompson	CAG
			5.7 Determine those aspects of inter-operability that can be delivered by the GNCR.	Scope out the IT systems being used currently and identify any potential problems and opportunities for inter-operability.	Jun-18	Karen Hooper	
			5.8 Agree the prioritisation and resources needed to progress inter-operability between systems with the Digital Care Programme Board.	Results of the scoping inform decision with Digital Programme Care Board.	Ongoing		
			5.9 Advise on the information to be shared across systems.	Professionals, organisations and women can share information across the system.	Jan-21		
		Exploit the opportunities of a Clinician's passport to support LMS working.	5.10 Understand how the development of Clinician's passport can support system working and integrate into programmes of work.	Recommendations to the LMS programmes of work about how they can use the clinicians passport.	STP timescale tbc	Andy Beeby, STP led	STP
	Data collection should be refocused on the most useful information so as to minimise the burden on women and their professionals.	A nationally agreed set of indicators should be developed to help local maternity systems track, benchmark and improve the quality of maternity services.	5.11 Keep up to date with progress in order to review results with Maternity Network Dashboard.		National timescale	Rachel Murray	CAG, MPSLN
	Multi-professional peer review of services should be available to support and spread learning.	Develop a process for identifying which case reviews would benefit from external input, co-ordinate the process and share lessons learnt across the region.	5.12 Establish and maintain process for ensuring externality at reviews.	A process for identifying which case reviews would benefit from externality.	Ongoing	Karen Hooper	MPSLN
				Record of external input into reviews and transferable learning shared.	Ongoing	Rachel Murray	MPSLN, Maternal and Neonatal Health Safety Collaborative
		Coordinate programme of observational site visits to develop network of critical friends across the three LMS footprints. Support sharing of good practice and feedback to the LMS Boards.	5.13 Agree process, format and purpose of observational site visits. Coordinate programme. Agree proforma for recording and communicating feedback from visits to share good practice across the region. Use process to develop network of critical friends.	Once defined develop a process for identifying which case reviews would benefit from external peer review.	Ongoing	Karen Hooper	MPSLN, Maternal and Neonatal Health Safety Collaborative, Provider Trusts

Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.							
	Aim (Better Births Recommendation)	**Objectives**	**Planned Activity**	**Measure / Success Criteria (A clear statement from both a service and service user perspective on how services will be different once the plan is implemented)**	**Milestone Timescale**	**Lead**	**Interdependencies with other work streams**
6	Providers and commissioners should work together in local maternity systems covering populations of 500,000 to 1.5 million, with all providers working to common agreed standards and protocols.	Standardise and implement common guidelines including use of referral pathways for general clinical scenarios.	6.1 Establish an LMS Labour Ward Guidelines Group and agree list of common standards and protocols.	A governance and ratification process for the implementation of common standards and protocols.	Jun-18	Stephen Sturgiss and Helen Simpson	Maternity CAG
			6.2 Develop standards and protocols and agree through the CAG to check any boundary issues then adopt through LMS.	Development of common standards and protocols and ensure local guidelines do not cause issues across boundaries.	Jan-21	Stephen Sturgiss and Helen Simpson	Maternity CAG
	Professionals, providers and commissioners should come together on a larger geographical area through Clinical Networks, coterminous for both maternity and neonatal services. They should share information, best practice and learning, provide support and advise about the commissioning of specialist services to support Local Maternity Systems.	Three LMS Boards work with the Clinical Network to deliver a Maternity Transformation Programme together by driving and sustaining change and transformation.	6.3 LMS SROs and Clinical Leads attend a joint Maternity Executive meeting.	Maternity Executive Group meets regularly throughout the year.	Ongoing	Andy Beeby, Julie Lane and Eleanor Hodgson	Maternity CAG
			6.4 Network groups are delegated leadership of specific aspects of the LMS plans where a network approach is most appropriate.	Clinical Network groups with delegated leadership provide progress updates on their plans to the LMS Boards.		Network Group Chairs, Network Delivery Leads	Maternity CAG
			6.5 Network Fetal and Maternal Medicine Groups established and able to provide support and advice about commissioning of specialist services.	Specialist advice is available when requested from the Clinical Network or alternative mechanism sought.		Therese Hannon and Jason Waugh	Maternity CAG
	Commissioners need to take clear responsibility for improving outcomes and reducing health inequalities, by commissioning against clear outcome measures and empowering providers to make service improvements and monitoring progress regularly.	Clinical Network and Commissioners work together through the standard maternity service specification to agree outcome measures by which to monitor and agree service improvements.	6.6 Review national specification when available.	Clinical Networks and Commissioners work together to agree a list of metrics to measure improving outcomes and mechanism for monitoring progress.	Jul-18	Gill Findlay, Chris Piercy and Stephen Sturgiss	CCG's, DCO Ops and Delivery Team
			6.7 Through network and involving all relevant parties, agree list of metrics using currently available metrics as a starting point, and including national metrics when available.				
			6.8 Set out a system for data collection and agree threshold parameters across the network.				
			6.9 Agree and implement a governance structure to oversee and monitor data collection.				

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.							
	Aim (Better Births Recommendation)	**Objectives**	**Planned Activity**	**Measure / Success Criteria (A clear statement from both a service and service user perspective on how services will be different once the plan is implemented)**	**Milestone Timescale**	**Lead**	**Interdependencies with other work streams**
7	The payment system for maternity services should be reformed so that it is fair, incentivises efficiency and pays providers appropriately for the services they provide.	In particular, it should take into account: The different cost structures services have. The need to ensure that the money follows the woman and her baby as far as possible, so as to ensure women's choices drive the flow of money, whilst supporting organisations to work together. The need to incentivise the delivery of high quality of care for all women, regardless of where they live or their health needs. The challenges of providing sustainable services in certain remote and rural areas.	Keep up to date with progress from the National Team and support implementation.				National Team

Neonatal							
	Aim	**Objectives**	**Planned Activity**	**Measure / Success Criteria (A clear statement from both a service and service user perspective on how services will be different once the plan is implemented)**	**Milestone Timescale**	**Lead**	**Interdependencies with other work streams**
8	Local Maternity System Transformation Plans will be jointly developed and delivered by neonatal and maternity services, the ODN and their respective commissioners.		8.1 Co-produce transformation plan aims and objectives and detail planned activity to implement improvements.	Complete - LMS plans submitted 31/10/2017, follow up meeting 21/12/2017, ongoing monitoring via dedicated 1 hour LMS slot at Neonatal ODN quarterly board meeting plus Neonatal ODN leads attending Maternity quarterly CAG.	Complete	NNN Manager and Clinical Lead	Neonatal ODN Board, Maternity CAG
	Review the capacity and demand data that accompanies this report,	Ensure that Neonatal services have the capacity to provide all neonatal care for at least 95% of babies who require admission for neonatal intensive care and are born to women booked for delivery in the network (i.e. no more than 5% of babies requiring intensive care born to booked women should be transferred out of network for inappropriate reasons).	8.2 Quarterly data monitoring and all Out of Area transfers for non-clinical reasons to be reviewed.	Monitored via quarterly LMS Data Reports and fed into annual Network Capacity Assessment that is drafted and produced for July Board meeting.	Ongoing	NNN Manager and Clinical Lead	Neonatal network, LMS Board, Specialist Commissioners and Provider Organisations
			8.3 Implementation of regional neonatal review	Full implementation of the neonatal review is a fundamental ambition of the regional STP. At operational level, detailed negotiations are underway between the relevant providers and the specialist commissioners	Teesside: Phase1 - implemented Sept 2017. Newcastle; Ongoing discussions between Specialised Com and RVI to agree funding. Phase 2 - aim is to complete by 03/09/18 so that all NIC babies will be transferred to JCUH from UHNT, which will then become a Level 1 SCU.	NNN Manager and Clinical Lead	
		Ensure that neonatal care services do not operate above the 80 percent occupancy averaged over the year.	8.4 Monitor and report figures for individual units at quarterly Neonatal ODN board meetings and also in LMS Quarterly Reports. This is relevant to the ambition to work at 80% occupancies - this links to the implementation of the regional review	Ongoing monitoring of capacity Phased implementation of increased cot capacity at RVI - business case submitted to NHS England - sign-off plans - recruitment - 2 cots to open 2018/19 - 2 cots to open 2019/20 - monitor occupancy following increased capacity and increase by another 3 cots	Ongoing There have been delays at NHS England with the business case submitted by NUTH now being referred to the regional NHSE "Regional Strategy & Transformation Board" who are undertaking "a more detailed analysis" for the Regional Leadership Group (RLG) so they can make a final decision.	NNN Manager and Clinical Lead	Neonatal network, LMS Board, Specialist commissioners & provider organisations
		Ensure that babies requiring neonatal services receive that care from a unit with the appropriate level of care as close as possible to the family home.	8.5	This will only be achieved by full implementation of the regional neonatal review and after expansion to accommodate new cots at the RVI. Metrics for measuring under to be confirmed	2020	NNN Manager and Clinical Lead	Neonatal network, LMS Board, Specialist commissioners & provider organisations
	Local Maternity System Transformation Plans will ensure that they have in place systems that enable an annual needs assessment, and gap analysis to ensure that adequate transfer capacity plans are in place.	Assess the reasons for babies being transferred because of lack of capacity (space or staff)	8.6 Quarterly NNN Reports - discussed at neonatal regional meeting and included in LMS Quarterly Reports	All transfers undertaken by NNeTs are currently categorised and reviewed.	Ongoing - Quarterly LMS Data Reports now being produced and diseminated	NNN Manager and Clinical Lead	Neonatal network, LMS Board, Specialist commissioners & provider organisations
		Review the reasons why babies are transferred for more specialised care.	8.7 All cases transferred	All transfers undertaken by NNeTs are currently categorised and reviewed.	Ongoing	NNN Manager and Clinical Lead	Neonatal network, LMS Board, Specialist commissioners & provider organisations
		Establish if any of the babies transferred in the first 3 days should have been born in an intensive care unit in the first place.	8.8 Reviewing all babies at < 30 weeks who are born in units without specialist neonatal facilities (see below), prioritising the higher risk infants, and plan to have a look at all babies after a process has been established to look at the 30 weeks or under babies	All transfers undertaken by NNeTs are currently categorised and reviewed.	Ongoing	NNN Manager and Clinical Lead CAG	Neonatal network, LMS Board, Specialist commissioners & provider organisations, MPSLN

Neonatal						
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	Local Maternity System Transformation Plans will ensure that they have systems in place that enable an annual needs assessment, and gap analysis to ensure adequate transfer capacity plans are in place.	8.9 Monitored via quarterly LMS Data Reports and fed into annual Network Capacity Assessment that is drafted and produced for July Board meeting	Complete - annual capacity assessment and report produced	Ongoing Annual Capacity Assessment Report for NNN Board should be ready for July 2018 highlighting current situation	NNN Manager and Clinical Lead	Neonatal network, LMS Board, Specialist commissioners & provider organisations
Review the admissions by gestational age data that accompanies this report to understand the local picture	Ensure that the ATAIN scheme and action plan are implemented	8.10 The ATAIN scheme to be a standing feature of all relevant neonatal and maternity network meetings	24/1/2018 - board meeting - each unit to feedback data about their own term admissions & action plans for reducing avoidable Term Admissions. This is now a requirement for the NHS Litigation Authority (NHS Resolution) reduction in annual premiums and is being "verified" by Neonatal ODNs	Ongoing	NNN/Maternity Services	Neonatal network, LMS Board, Specialist commissioners & provider organisations, MPSLN, MatNeo PSC
	Monitor the levels of term baby admissions in neonatal units	8.11 Core metric of Quarterly LMS and NNN Reports	Quarterly and annual report produced.	Complete	NNN/Maternity Services	
	Engage with Maternity Neonatal Patient Safety Collaborative	8.12 Bespoke support for Trusts according to need based on neonatal content (if any) of their MNHAC plans. NNN Manager feeds into regional team overseeing the work.		Ongoing	NNN/Maternity Services	
Review progress against local workforce plans in place to address staffing issues.		8.13 Review the outcomes of the Quality Surveillance Team (QST) peer review visits and ensure work is being undertaken to address the risks and concerns identified as part of the local transformation planning.	Develop action plan with timescales once reports received which are specific to each unit with oversight from NNN	Awaiting final peer review reports - expected in new year These are now in place and common themes were discussed and where possible, been incorporated into NNN Annual Work Plan for 2018-19, although most are for individual NNUs to address	NNN Manager and Clinical Lead	
		8.14 Carry out a capacity review to determine the correct level of cots and their distribution across local maternity systems.		Covered by 8.9	NNN Manager and Clinical Lead	
		8.15 Specialised Commissioning Hub Teams to share the quality dashboard metrics relevant to the providers within the local maternity system to inform local transformation planning. This is planned to expand to 6 items for Neonatal care		2020/21 - detailed timescales will be included after Neonatal and Maternity teams have agreed these	NNN	
Specialised Commissioning Hub Teams to share the quality dashboard metrics relevant to the providers within the local maternity system to inform local transformation planning.	LMSs will ensure that, where possible, all women <27 weeks are able to give birth in centres with a neonatal intensive care unit (NICU).	8.16 Exception reporting of any baby <30 weeks born outwith NICU - Quarterly report to be presented to NNN Board and included within LMS board updates. National Directive is for babies <27/40 to have an "independent review" where this pathway is not adhered to. NNN is reporting on <30/40 exceptions as this is our own Network Pathway. Process for reviews needs to be agreed. See 8.19	Ongoing case by case audit	Ongoing	NNN/MPSLN	Neonatal network, LMS Board, Specialist commissioners & provider organisations, MPSLN, HSIB, Child death overview panel, Maternity neonatal deaths RCAs involving external input
	LMSs and Operational Delivery Networks (ODN) will have clear guidelines for antenatal transfer in the event of impending delivery < 27 weeks, as part of the shared clinical and operational governance being developed across LMSs.	8.17 Pathways in place for 30-32 week transfer arrangements Guideline to be developed - for discussion and implementation. Already begun	Agree guideline development for a joint maternity and neonatal guidelines		NNN CAG	
	LMS and ODN will aim to ensure at least 85% of all births at 23-26 weeks of gestation are in a maternity service with an on-site NICU. Include actions to deliver this in local transformation plans.	8.18 Exception reporting of any baby <30 weeks born outwith NICU - Quarterly report to be presented to NNN board & included within LMS board updates Implementation of regional neonatal review NNN performs very well indeed in this - national best score	Ongoing audit - report to be shared at CAG & NNN ODN	Ongoing	NNN/MPSLN	

Neonatal						
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	ODN will report and investigate exceptions to this rule. Investigation includes an independent review of the case, feedback of lessons learnt to the local team, and through the LMS, Maternity Clinical Network and ODN for wider dissemination where appropriate.	8.19 Ongoing audit of all deliveries <30 weeks occurring outside of units with Neonatal ITU	Ongoing audit - report to be shared at CAG & NNN ODN	Ongoing	NNN/MPSLN	
	LMSs will ensure that all neonatal deaths are investigated at a local level using a standardised framework including root cause analysis and reported nationally to support learning.	8.2	Await national Health Safety Investigation Branch implementation. Await report and updated CDOP arrangements. Link to MPSLN RCA terms of reference	Still awaiting details of HSIB process	NNN Manager & Clinical Lead	
	Each Baby Counts (RCOG) investigates local review quality for term babies.	Local maternity systems and networks will ensure that, following birth at 23 weeks of gestation or more, every death (100%) in the delivery room and neonatal unit is investigated, and that lessons are learned, implemented and shared though Maternity Clinical Networks.	Await national Health Safety Investigation Branch implementation. Await report and updated CDOP arrangements. Link to MPSLN RCA terms of reference	Still awaiting details of HSIB process	NNN/Maternity Services	
	Trusts will adopt appropriate methodology as it becomes available, including the Perinatal Mortality Review Tool (https://www.npeu.ox.ac.uk/pmrt) and the Child Death Audit Guidance, both of which will be published by the end of 2017 and in line with the Serious Incident Framework.		PMRT will be implement once available. Tool now available and being used. Responsibility lies with individual units to comply with encouragement to use from NNN.	From January 2018	NNN/Maternity Services	
Local Maternity System Transformation Plans will include a 'neonatal mortality theme' and as the work progresses through the Neonatal Mortality Group, its findings and recommendations will be incorporated into local Transformation Plans	Improvement/reduced variation in the administration of prophylactic medicine to optimise outcomes i.e. Antenatal Steroids and Antenatal Magnesium Sulphate	Monitored and reported figures for individual units at quarterly Neonatal ODN board meetings, audit of exception reports		Ongoing - audit to commence June 2018	NNN/Maternity Services	Neonatal network, LMS Board, Specialist commissioners & provider organisations, MPSLN, MatNeo PSC
	Development of formal Neonatal Transitional Care in Trusts to reduce separation, improve capacity in neonatal units and improve families and carers experience. Assessment of current provision and sharing of good practice.	8.21 Benchmarking of current provision available at each unit to be carried out NNN now has more clarity on current provision for TC, however this has been blurred by the NHS Resolution audit mandating compliance for annual premium reduction.			NNN/Maternity Services, CCG and Specialist commissioning	Neonatal network, LMS Board, Specialist commissioners & provider organisations, MPSLN, MatNeo PSC
	Provide ongoing support for Neonatal Outreach services which will result in improved capacity in neonatal services, reduce length of stay and improve family and carers experience.	8.22 CQUIN target agreed with RVI & JCUH. Await results and impact assessment, may factor in peer review reports, involve paediatric outreach services. Await national guidance.	Agree action plan with timescales when results of all measures known		NNN Manager and Clinical Lead	

	Prevention						
	Aim	**Objectives**	**Planned Activity**	**Measure / Success Criteria (A clear statement from both a service and service user perspective on how services will be different once the plan is implemented)**	**Milestone Timescale**	**Lead**	**Interdependencies with other work streams**
9	Reduce smoking in pregnancy (SiP)	Implement NICE guidance systematically in every maternity unit	9.1 Audit baseline of pre / post SiP	Completion of baseline audit, prevention event	5% SATOD by 2025 in line with regional ambition. October 2018	Alisa Rutter Ruth Bell Allison Metters LMS Prevention Co-ordinators	Provider Trusts
			9.2 Share good practice across region, host an event.				Maternity Network
			9.3 Support STP prevention workstream to encourage the NHS trusts to be smoke free.				STP Prevention
	Increase uptake of flu and pertussis vaccination in pregnancy	Effective and clear commissioning of all maternity units in the LMS	9.4 Explicit remuneration to maternity services to deliver vaccinations in pregnancy. [NHS England have offered providers the opportunity for midwifery teams to deliver flu and pertussis vaccinations to pregnant women attending antenatal clinics. NHS England are working with all FTs to commission this service]	Vaccinations commissioned.	95% uptake by 2025 Interim ambition: 90% by 2020	Rachel Chapman Kate Birkenhead LMS Prevention Co-ordinators, LH PH Lead	
	Improve perinatal mental health	Standardised implementation of perinatal MH pathway implemented across LMS	9.5 Align local pathways to the wider offer of support in the communities.	A)100% of women assessed during pregnancy by 2025 B)100% of women requiring specialist support being seen by 2025 C)Interim ambition: 90% of women		Gill O'Neill, Linda Vasey	Perinatal Mental Health Network, Postnatal Care
		PMH Training for non perinatal mental health specialists	9.6 PMH Institute Health Visiting train the trainer programme and cascade training to front line maternity, 0 - 19 and children's services				Institute of Health Visiting, HOMs, Perinatal Mental Health Network
	Reduce alcohol in pregnancy (AiP)	Determine standardised assessment for alcohol consumption in pregnancy	9.7 Standardised assessment methodology for alcohol consumption in pregnancy.	Less than 5% of women drink alcohol in pregnancy by 2025 Interim ambition: Less than 10% by 2020		Judith Stonebridge NHCT Maternity Unit Susan Taylor LA PH Lead LMS Prevention Co-ordinators LMS Midwifery	
		Baseline data / intelligence using standardised assessment tool	9.8 Baseline data using standardised assessment tool for 100% of patients. Possible audit from the network. Cumbria trialling carrying device with community midwives.				
		Design, implement and evaluate brief interventions for maternity units / community	9.9 Design, implement and evaluate brief interventions for health care professionals and develop implementation plans.				
	Increase breastfeeding (BF) initiation and 6 – 8 weeks	Implement Unicef UK Baby Friendly accreditation requirements as an LMS	9.10 Gap analysis produced by Unicef UK Baby Friendly accreditation.	100% maternity units / community settings at level 3 Unicef UK Baby friendly accreditation by 2025. Interim ambition: 100% units at level 2 2020		Helen Martin Regional Infant Feeding Group	
			9.11 Share good practice and learning				
		Contribute towards changing the social norm in society	9.12 Build on the conception to early years work completed within the Network.	BF rates for LMS at initiation and 6 – 8 weeks equivalent to or greater than rates for England by 2025			
	Promoting healthy weight and supporting women who are obese pre-conceptually, antenatally and postnatally.	Baseline data / intelligence using standardised assessment process	9.13 Baseline data using standardised assessment tool for 100% of patients.	Pre conception: 100% women are given healthy weight / nutrition advice at contraception clinics and family planning in primary care by 2025		Kay Branch	
		Implement NICE guidance systematically in every LMS (maternal and child nutrition and weight management before, during and after pregnancy)	9.14 Benchmark data against NICE guidance.	Pregnancy: 100% women with BMI >30 are supported using NICE guidance recommendations by 2025.		Kay Branch & Nicola Heslehurst	
		Promote CMO guidelines for physical activity in pregnancy	9.15 Build on the conception to early years work completed within the Network.	Postnatal (6 – 8 week check): 100% women with BMI >30 signposted to structured weight management programme by 2025		Kay Branch, Nicola Heslehurst Gill O'Neill	STP
			9.16 Share good practice and learning to understand baseline activity.				
		Contribute towards the wider STP work on obesity and healthy lifestyle	9.17 Share good practice and learning	Interim ambition: 80% women by 2020			STP
	Increase making every contact count (MECC)	MECC and prevention training mandatory in all maternity units and community settings	9.18	100% staff trained in MECC by 2025		Judith Stonebridge	Regional Strategic MECC
		HEE develop prevention accredited units	9.19	Interim ambition: 80% staff trained by 2020			HEE