Sussex & East Surrey
Sustainability & Transformation Partnership

Local Maternity System Plan

Our vision for improving safety, choice and personalisation in maternity services

January 2019

Supporting **better births** in **Sussex and East Surrey**

Contents

1 Executive summary

Nationwide, maternity services face an increasing challenge of improving outcomes in the context of increasing prevalence of risk factors and growing expectations from women. The Local Maternity System (LMS) plan targets improvements in line with the Better Births Strategy in four core outcomes:

1. **Safety and perinatal mortality:** reducing stillbirth and neonatal mortality rates by 20% by 2020 and 50% by 2025 and saving 51 lives per year by 2025
2. **Health inequalities and unwarranted variation:** ensuring all women are offered high-quality care regardless of geography, circumstance or background
3. **Access to perinatal mental health services:** identifying early and supporting the mental health and well-being of women and families throughout the perinatal period
4. **Maternal experience:** working with women and families to provide a kind, caring and personalised maternity journey and co-designing services to meet women's needs

Local context and challenge

"Sussex & East Surrey sees approximately 19,000 births per year, at a cost of £109 million."

Birth rates across the region are forecast to remain constant to 2025. However, implementing mandated best practice and growing Clinical Negligence Scheme for Trusts (CNST) contributions put pressure on the sustainability of services. The region provides an overall "good" service with pockets of real strength and excellence. However, services are facing significant challenges to the quality and sustainability of their offering:

Safety and perinatal mortality

In 2016, the LMS reported 101 perinatal deaths with an average mortality rate below the UK average: 5.26 per 1,000 live births compared to 5.64 per 1,000 nationally. It is noted that UK rates are significantly worse than comparable countries, ranking 19th of the 28 EU members. Associated with this are high rates of modifiable maternal risk factors (including smoking and obesity), workforce challenges which limit roll-out of best practice guidelines and rising CNST contributions.

Health inequalities and unwarranted variation

Getting It Right First Time (GIRFT) and Care Quality Commission (CQC) assessments identify gaps and unwarranted variation in: outcomes and intervention rates, capacity, culture, data validation, incorporation of patient feedback and availability of specialist services. The case for reducing inequality is well proven in the literature. For example, black and minority ethnic (BME) women have 2-5 times higher mortality rates, teenage pregnancies have a 60% higher infant mortality rate and older women are 1.5 times more likely to experience pre-term birth. The LMS will actively consider, assess and ensure it meets its equality duties as part of its normal business.

Access to perinatal mental health services

Good quality, evidence-based perinatal mental health care pathways have been shown to improve access, lower mortality rates and reduce psychosocial needs in children. Access to specialist services relies on strong links between women and families and maternity staff. These are not universally in place: some women with mild and moderate needs go without the right support due to delays in identification and accessing care or indeed lack of services able to meet their specific need.

Maternal experience

For many women, pregnancy is the first time they have sustained contact with health services. Involving women in their care (through increased choice and personalisation) and providing a positive experience is key to delivering all four core improvement outcomes within the LMS. When women are more involved in their care, there is evidence to suggest they experience better outcomes and make lasting positive changes to their lifestyle, in line with longer term NHS strategy.

Site-level volumes and staffing

All trusts have recently been assessed using Birth Rate Plus which is a tool that assesses current configuration of midwifery services. This identified workforce gaps within the current midwifery service and there are developing plans to address these gaps. When comparing weekly hours of consultant cover with national standards[1], all sites meet minimum levels, however several sites have fewer than 2,500 births.

Vision: a changing approach to maternity services

Acknowledging the critical role of maternal involvement in driving improvements, the LMS programme aims to strengthen links with women, putting them and their families at the heart of maternity services. The LMS will work to empower every service user to make real, informed, choices about their care, supported by collaborative relationships with healthcare staff, access to care in the community, and ultimately services which are co-designed to meet their needs.

Delivering the future vision for maternity services will have substantial short and long-term benefits for the Sussex & East Surrey health and social care system:

- improved safety and outcomes
- improved population health
- better staff and user satisfaction
- increased service sustainability
- better value maternity services

Through an evaluation of current services with a gap analysis against national recommendations and local best practice, the LMS has identified several service improvement opportunities. Providers (working with commissioners) are responsible for delivering the majority of these with the LMS supporting improvement through co-design with women and system collaboration.

"Rising costs will lead to a financial pressure of £6-8 million in the next five years under a do-nothing trajectory."

With maternity CNST contributions forecast to reach over £26 million by 2022/23, the Sustainability and Transformation Partnership (STP) must prioritise improving outcomes and safety to reduce claims. Targeted investment in optimising midwifery workforce, implementing continuity of carer and implementing serial growth scans may be able to deliver substantial cost savings through improved quality and reduced CNST premiums. It needs to be recognised that in some organisations the Still Birth rate is already below the England average and with the challenge to reduce this further the quality gain will be primarily in improving patient satisfaction.

1 *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour; Royal College of Obstetrics and Gynaecology, 2007*

To optimise the financial sustainability of the LMS, partners should:

- Collaborate to ensure providers consistently secure any available CNST discounts relating to maternity contributions
- Require that subsequent investment proposals are rigorous and demonstrate an increase in the value per pound of healthcare spend
- Explore costs relating to Perinatal Brain Injury (PBI) and use the insights to appraise proposed investments to reduce rates of PBI

Role of the LMS

The LMS will support providers to unlock the full benefits of the Maternity Transformation Programme in three ways:

Co-designing services with women and families

Bringing together women, providers and commissioners at STP scale is a critical role of the LMS and will enable ongoing involvement and co-design of services with women and families through Maternity Voices Partnerships (MVPs). MVPs are the long-term forum for service user engagement and the LMS will support a consistent approach across Sussex and East Surrey to ensure they play a continued role in the development of maternity services to allow services to develop guided by the needs of local families.

Supporting local organisations to deliver change

The LMS will enable continuous quality improvement and robust transformation planning by evaluating long-term and/or system implications (e.g. workforce, patient flows and activity analyses, system-level evaluations), linking local organisations to central bodies (NHSE, NHSI, HEE, PHE), and aligning system priorities and transformation plans.

Leading system-wide collaboration & transformation to drive quality improvement

National guidance offers scope for local systems to innovate and design their own services, working across boundaries to develop services that meet the need of the local population.

The LMS programme will enable this system wide collaboration and transformation in two distinct phases. The first phase will focus on breaking down structural and cultural barriers to facilitate cross-organisational service improvement, including:

- Creating a culture of collaboration through leadership development and shared learning forums to develop high performing teams which embed continuous quality improvement within their practice and culture
- Enabling cross-organisational working by putting in the underlying infrastructure, including a single service specification, standardised policies and protocols, an outcomes-based commissioning model and an interoperable digital system.
- Tackling common issues together and developing a coordinated response and improvement plan across the system – initially this will focus on understanding of workforce gaps, provision of prevention services and access to perinatal mental health.

The second phase will identify the opportunities and challenges that can only be unlocked through collaboration, identifying opportunities for joint service improvement such as use of a single common training curriculum, joint delivery of community hubs, shared specialist roles or the development of regional specialist services. This will support and supplement the work of each partner to increase the overall quality, resilience and sustainability of the system of care.

Delivering the vision

Running the LMS programme

The LMS has distilled the full range of improvements into a defined programme of work, to be implemented over the next five years, organised into nine workstreams. The core LMS team will be responsible for coordinating and delivering this plan, with progress discussed within the LMS Stakeholder Group and reported to the LMS Programme Board, the established STP governance structure, individual partner boards and regional and national NHSE Maternity Transformation Boards.

Non-recurrent programme costs are funded centrally through the Maternity Transformation Programme, with some central funding available for set up and transitional costs. The LMS assumes flat, real-terms funding increases, but are conscious of the additional demands placed on services by some national recommendations. The LMS is committed to evolving maternity services towards commissioning for outcomes, developing the approach and standard specification collaboratively between providers and commissioners.

Collaboration with other STP programmes of work

There is considerable overlap between the LMS and the broader STP in the challenges faced and the work needed to address them – for example digital and workforce strategies. This will be formalised through regular reporting and assurance within the established STP governance structures.

Aspects of the LMS programme will need input from the STP Executive Group to make strategic choices on the direction of travel, with implications for the improvements achieved and investment required. Priority areas include implementing Continuity of Carer teams, which will place demands on existing maternity workforce and will require review of current delivery models. Other priorities include funding of the Perinatal Mental Health Network and an increased focus on prevention services.

"The LMS is excited by the opportunity this plan represents and is committed to transforming care for women, fathers and babies by strengthening collaboration between all involved partners."

2 Introduction

Nationwide, maternity services are changing. The National Maternity Review: Better Births describes a vision for safer, more personalised, kinder, professional and more family friendly maternity services, where women are empowered to make real choices and families can access support centred around their individual needs and circumstances.

Building on this vision, the National Maternity Safety Strategy sets an ambitious target of halving perinatal mortality by 2025. The transformation agenda set by these represents a paradigm shift in how maternity services are organised and delivered, with a greater emphasis placed on co-design with women and their families and system-wide collaboration.

The LMS will embody these principles to deliver transformative change within the Sussex & East Surrey region, improving safety and outcomes, population health, staff and user satisfaction, and delivering increased service sustainability, resilience and better value maternity services.

Services are under growing strain from more resource intensive management of higher risk pregnancies, driven by higher proportions of older women and increasing prevalence of obesity, rising costs and widening workforce gaps in key staff groups. With the exception of specialist perinatal mental health, investment is limited to non-recurrent programme costs and all providers face challenging efficiency targets.

In this context, Local Maternity Systems must work together to achieve improvements through innovative delivery models and collaboration in a financially sustainable way.

3 Local context: maternity services in Sussex & East Surrey STP

The LMS brings together the 24 organisations within the Sussex & East Surrey STP, including commissioners, providers and local authorities, making it one of the largest and most complex in the country. Together these services provide care for approximately 19,000 live births annually, delivering maternity services within four acute providers and across seven sites. Additionally, Sussex Partnership NHS Foundation Trust provides specialist Perinatal Mental Health services, while local authorities are responsible for prevention services and commissioning health visiting.

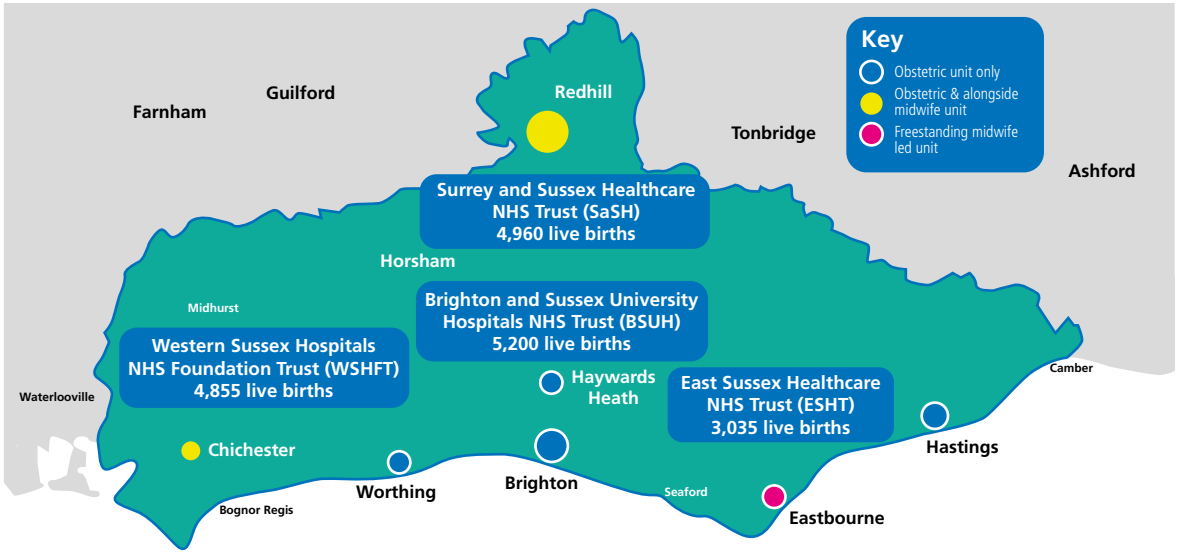

Figure 1: Maternity services within Sussex and East Surrey, with 2017/18 live births/trust (Source: NHS Maternity Statistics)

Cost of care totalled £109 million in 2017/18, with intrapartum obstetrics and health visiting representing 81% of spending.

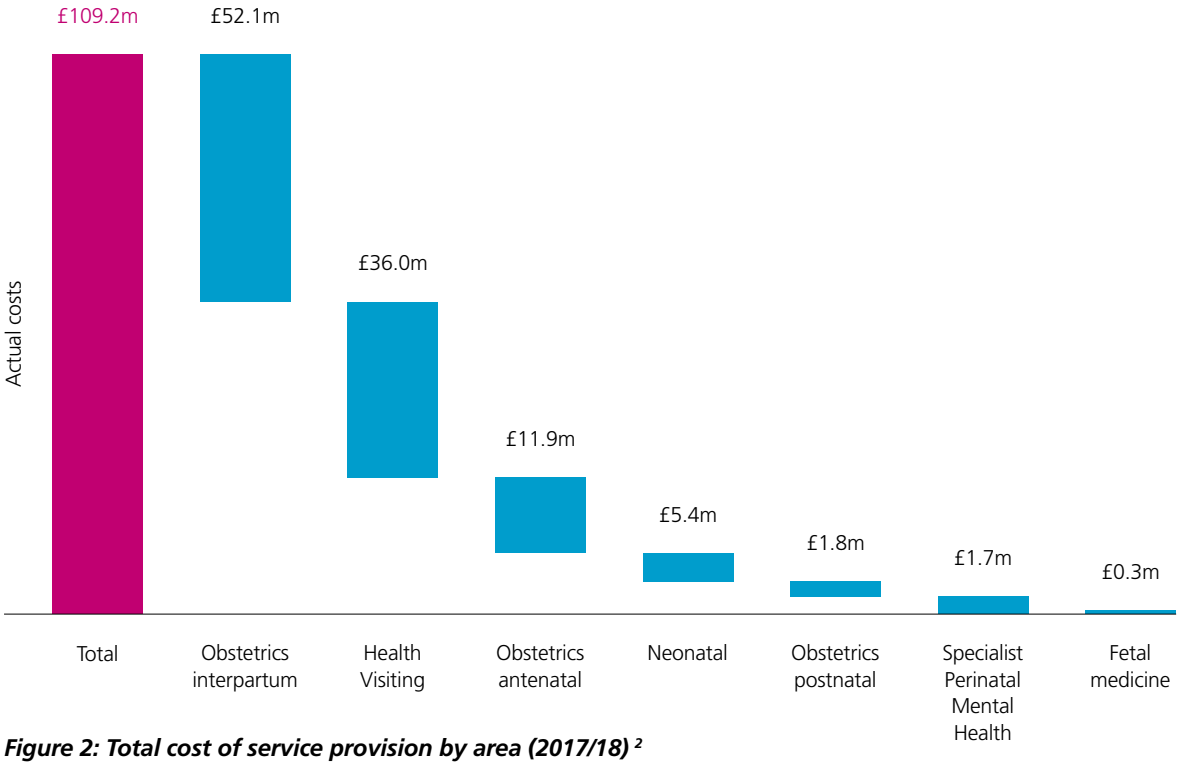

Figure 2: Total cost of service provision by area (2017/18) [2]

The LMS footprint has a population of 1.7 million people. 15% to 25% are women of reproductive age. Birth rates have been stable since 2013 and are forecast to remain constant through to 2025, with the picture consistent across the four constituent areas. However, local intelligence suggests significant house building aimed at starter homes and young families may alter this picture.

2 *Costs shown are 17/18 reference costs actual costs (unadjusted) for Sussex and East Surrey providers. PNMH costs are estimated through conversation with S. Allen on 14th November 2018*

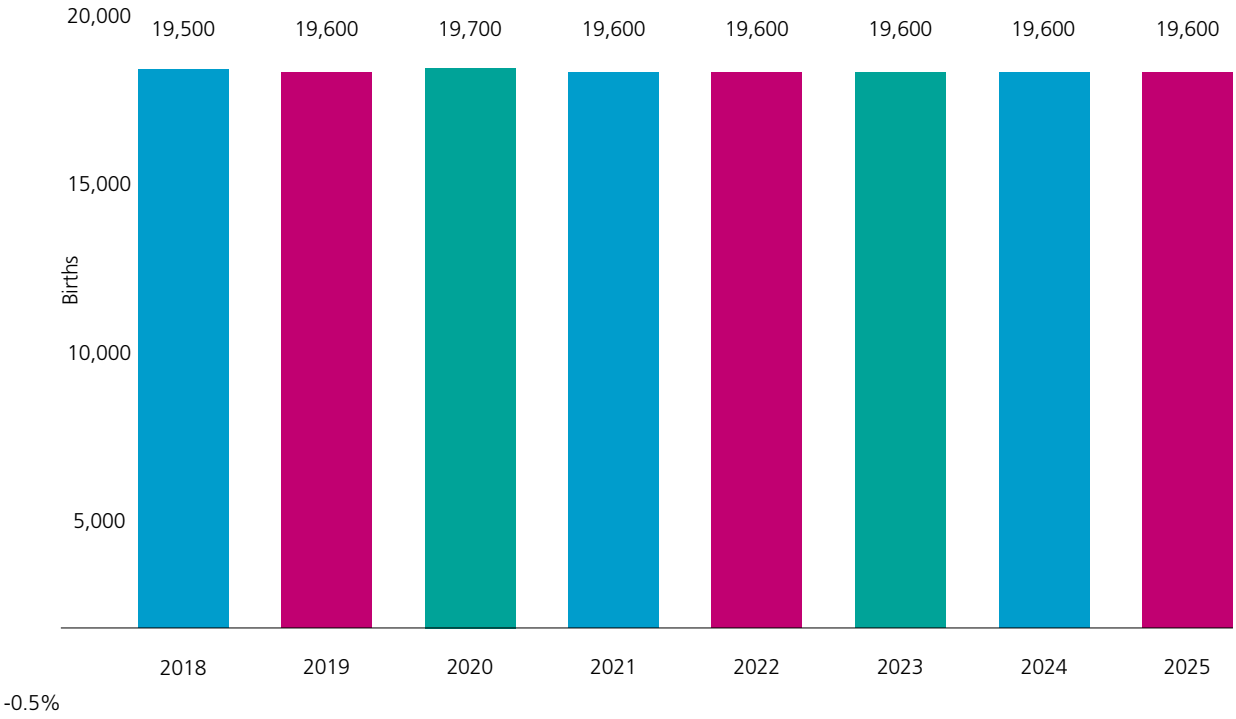

Figure 3: ONS Sussex and East Surrey birth projections 2018-2025 [3]

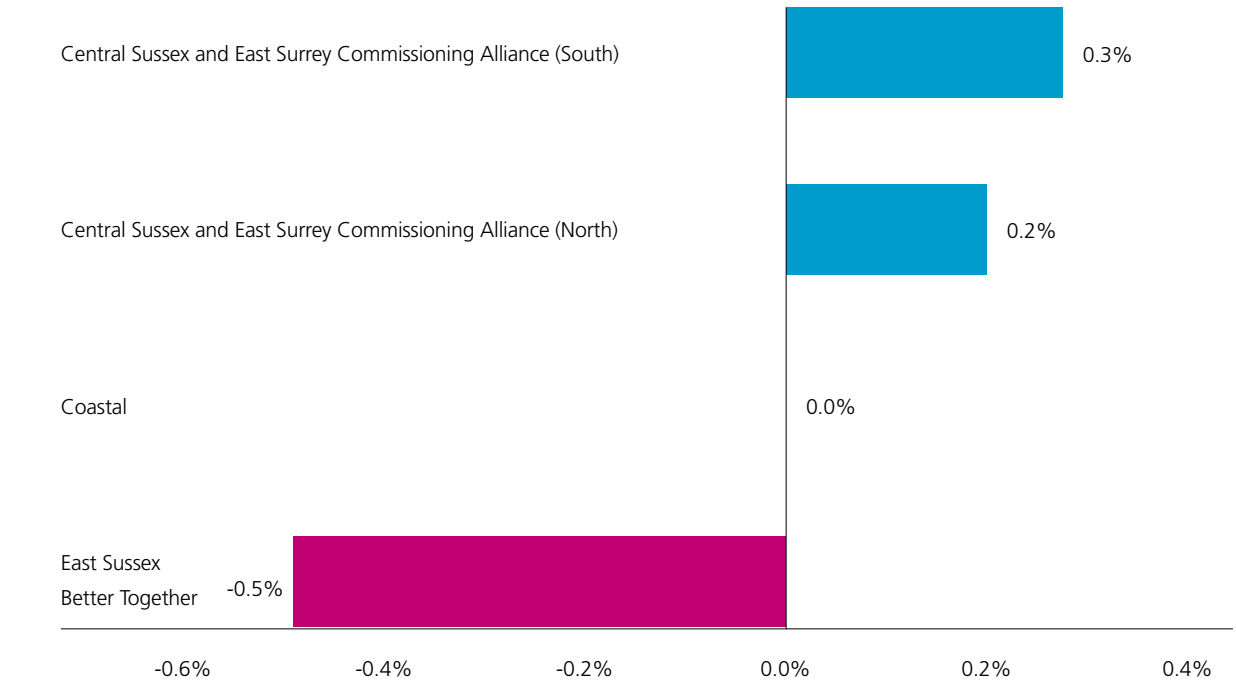

Figure 4: Birth projections by place: Compound annual growth rate (CAGR) 2018-2025

The complexity of cases is increasing, driven by a growing proportion of women over 35 and rising obesity rates.

3 ONS Population projections, produced 2016, accessed November 2018. These projections do not consider development policies but include estimates of migration into and out of the region

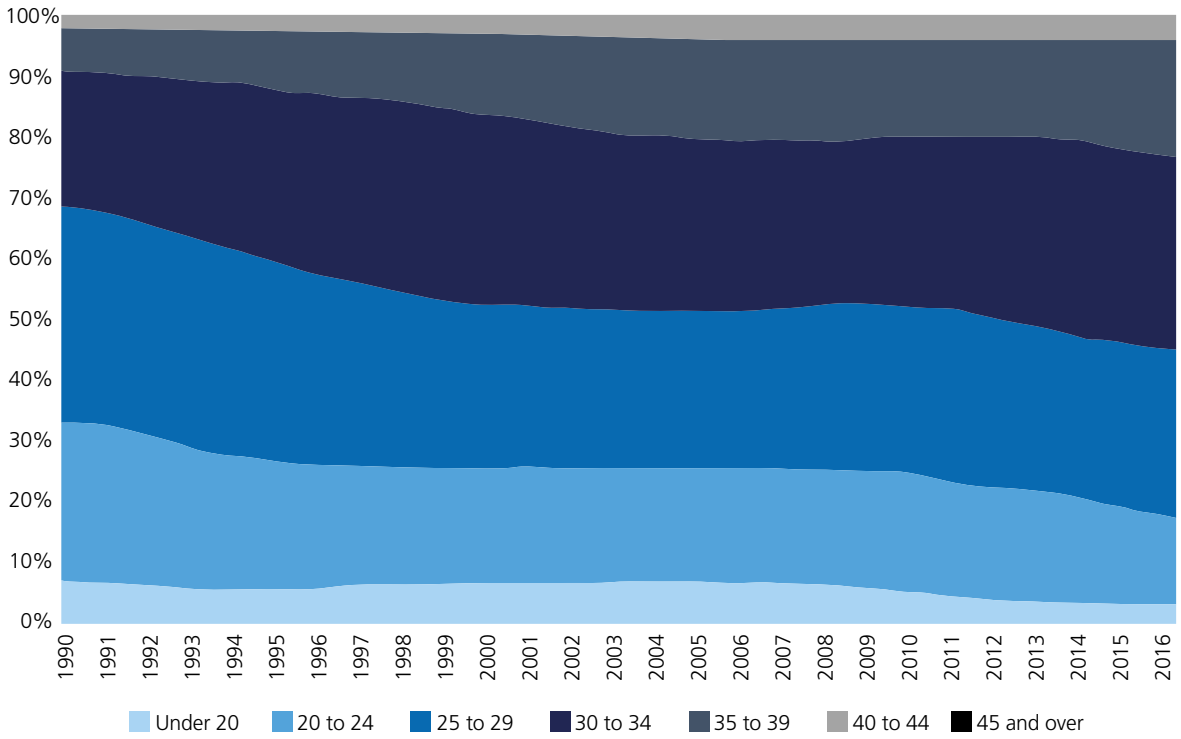

Figure 5: Live births by age of mother in England and Wales [4]

4 Current challenges and the case for change

4.1 Safety and perinatal mortality

In 2016, the LMS reported 101 perinatal deaths with an average mortality rate of 5.26 per 1,000 live births (national average is 5.64 per 1,000).

Based on crude rates and adjusting for risk factors, seven of eight Clinical Commissioning Groups (CCGs) are between 0 to -10% from UK average. Coastal West Sussex is between 0 to +10%, thought to be due to high maternal smoking rates, which are currently being triangulated, reviewed and analysed. UK rates are significantly higher than comparable countries, ranking 19th of 28 EU members. Halving perinatal mortality by 2025, as per the National Maternity Safety Strategy, could potentially prevent 51 deaths per year in Sussex and East Surrey, but will require the LMS to address the high prevalence of modifiable maternal risk factors, and increase workforce capacity to identify and manage at-risk pregnancies. The LMS anticipates close collaboration with neonatal networks to address this.

4 Sourced from ONS datasets, live birth by age of mother 1980-1999 and 2000-2016

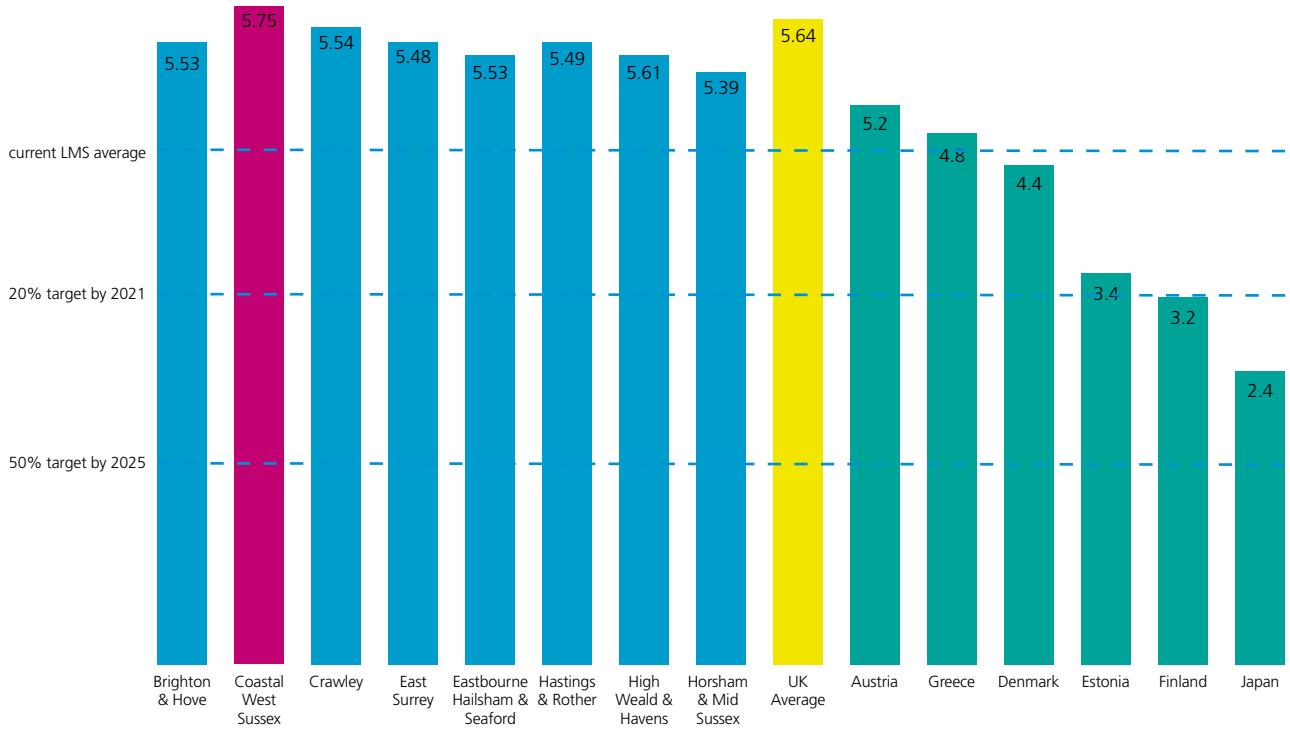

Figure 6: Extended perinatal mortality rate by CCG and international comparison [5]

4.1.1 High prevalence of modifiable maternal risk factors

Maternal smoking increases the risk of stillbirth by 47%[6] and is the greatest risk factor for perinatal mortality. Local smoking rates show a large variation, with high rates seen in Hastings and Rother, Eastbourne, Hailsham and Seaford, and Coastal West Sussex CCGs. Only two CCGs report smoking at time of delivery (SATOD) rates below the national target of 6%, and rates have increased in a further four of the eight CCGs in 2017/18, as shown in Figure 7.

Smoking cessation during pregnancy reduces the risk of stillbirths and sudden infant death syndrome (cot death), as well as pre-term labour, low birthweight babies and complications during pregnancy[7]. Targeted smoking cessation support is effective at reducing maternal smoking; however there is variation in smoking cessation rates across Sussex & East Surrey. Accurate identification of women who smoke through carbon monoxide (CO) breath testing, tailored advice, and targeted prevention services are needed across Sussex & East Surrey to reduce maternal smoking rates and improve outcomes.

5 *Perinatal defined as stillbirths occurring >20 weeks gestation and early neonatal deaths (<7 days postnatally). UK data from MBBRACE 2016 Mortality report, international data from OECD.Stat 2016 Perinatal mortality stats*

6 *Maternal smoking and the risk of still birth: systematic review and meta-analysis; Takawira C Marufu, Anand Ahankari, Tim Coleman and Sarah Lewis BMC Public Health 2015, 15:239 doi:10.1186/s12889-015-1552-5*

7 *Royal College of Physicians. Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010*

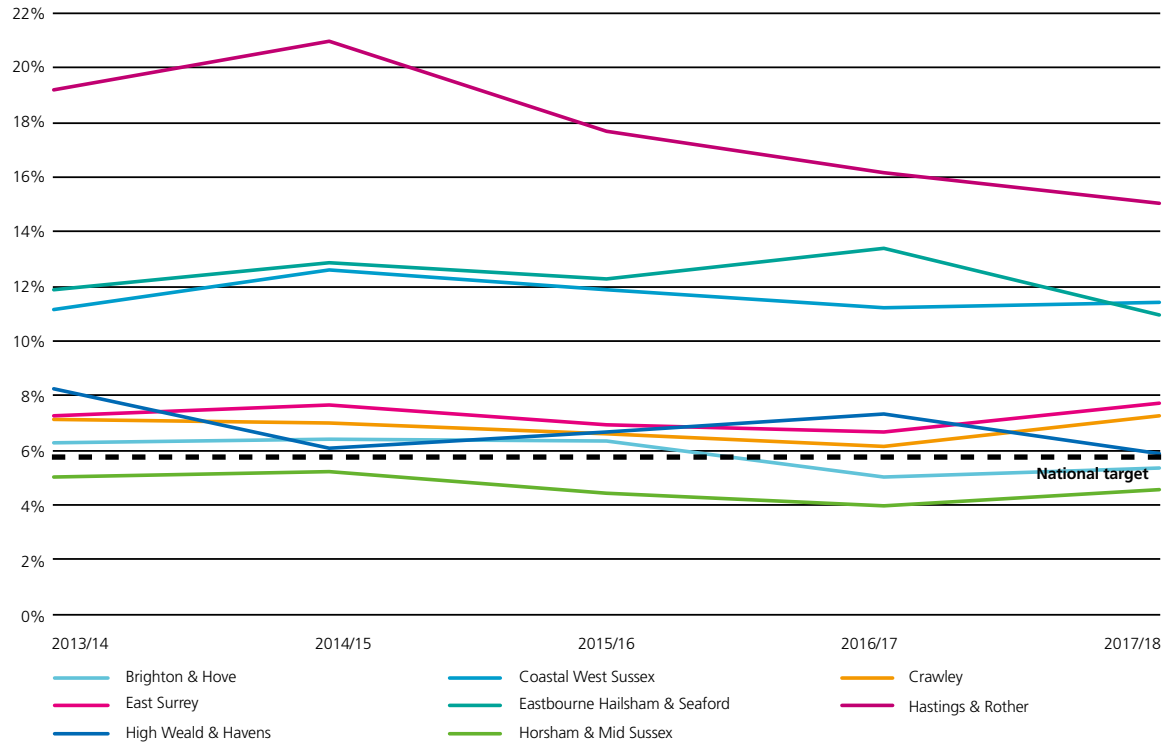

Figure 7: Smoking at the time of delivery rates, 2013-2018 [8]

Obesity rates have been steadily increasing over the past decade, in line with national trends. On average, 20% of women are obese at the start of their pregnancy with a further 25% overweight. These women have an increased risk of adverse maternal and fetal outcomes and higher intervention rates, requiring increased medical input during pregnancy and labour, for example due to the increased likelihood of developing gestational diabetes. Therefore, increasing obesity rates are associated with increased service demand and cost per birth. Western Sussex Hospitals provide a specialist service for weight management in pregnancy, but there is urgent need for coverage through the rest of the LMS.

8 NHS Digital Smoking at time of delivery statistics, accessed November 2018

4.1.2 Workforce and capacity challenges

Since 2010, multiple national initiatives have been launched to reduce perinatal mortality, including the Saving Babies' Lives Care Bundle (SBLCB), Avoiding Term Admissions into Neonatal Units (ATAIN) and Each Baby Count[9]. Implementation of the SBLCB is seen as critical for providers, forming part of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme for full roll-out by March 2019. All four of the SBLCB interventions place increased demands on services with a downstream effect on the scale and skill-mix of the workforce required, as shown in Table 1.

Intervention	Implementation challenge for Sussex & East Surrey
Reducing smoking in pregnancy	• Time restrictions on antenatal appointments limit the counselling and advice staff can provide women • Smoking cessation services have limited capacity for new referrals • Limited access to smoking cessation services in some areas
Surveillance for fetal growth restriction	• Shortfall in ultrasonographers limits capacity to increase the number of scans offered per service user • Additional training requirement for use of customised growth charts • Limitations with customised growth chart in management of large for Gestational Age Babies
Raising awareness of reduced fetal movement	• Difficulty staffing 24/7 triage lines and high volumes of calls, means women do not have easy pathways to raise concerns • Some Provider units[10] offer 24/7 triage service
Effective fetal monitoring during labour	• Low midwife: birth ratios mean 1:1 intrapartum care cannot be provided for all women • Need for increased standardisation of CTG interpretation, including regular training, use of 'fresh eyes' protocols and rapid escalation pathways which increase demands on clinician time

Table 1: Workforce challenges associated with Saving Babies Lives Care Bundle

Challenges are amplified by the increasing complexity of pregnancies. A key focus for the LMS will therefore be to define the strategic system-wide workforce shortages and develop recruitment, retention and training solutions to address these.

9 *Saving Babies Lives targets early identification and management of at-risk pregnancies, ATAIN optimises postnatal care and Each Baby Counts address continuation of human factors to poor outcomes*

10 *Some units at Surrey and Sussex Healthcare Trust offer a 24/7 triage service.*

4.1.3 Rising cost per birth associated with increasing complexity and CNST payments

Total costs of maternity services are increasing, driven primarily by Clinical Negligence Scheme for Trusts (CNST) contributions.

Increasing complexity is associated with a growing proportion of mothers aged over 35, rising obesity rates and rising maternal comorbidities (including gestational diabetes) – these require greater specialist input antenatally, are associated with higher rates of intervention during labour and increased need for postnatal support (including longer inpatient stays)[11]. Analysis of HRG case mix between 15/16 and 17/18 shows there is a large reduction in the lowest level of acuity with almost all other levels seeing growth. The HRG average cost analysis provides one perspective and is affected by various data quality factors as well as the timing difference between changes in clinical procedures (e.g. intervention on still birth rates) and diagnoses against the setting of HRG criteria. The change indicated is relatively small; comment from midwives and obstetricians, and the data about the age of mothers and other factors suggests an alternative view on acuity. As an STP we will look to find a clinically agreed description of 'acuity' to better support our strategy.

Maternity delivery episodes by acuity level NHS reference costs 15/16 vs 17/18

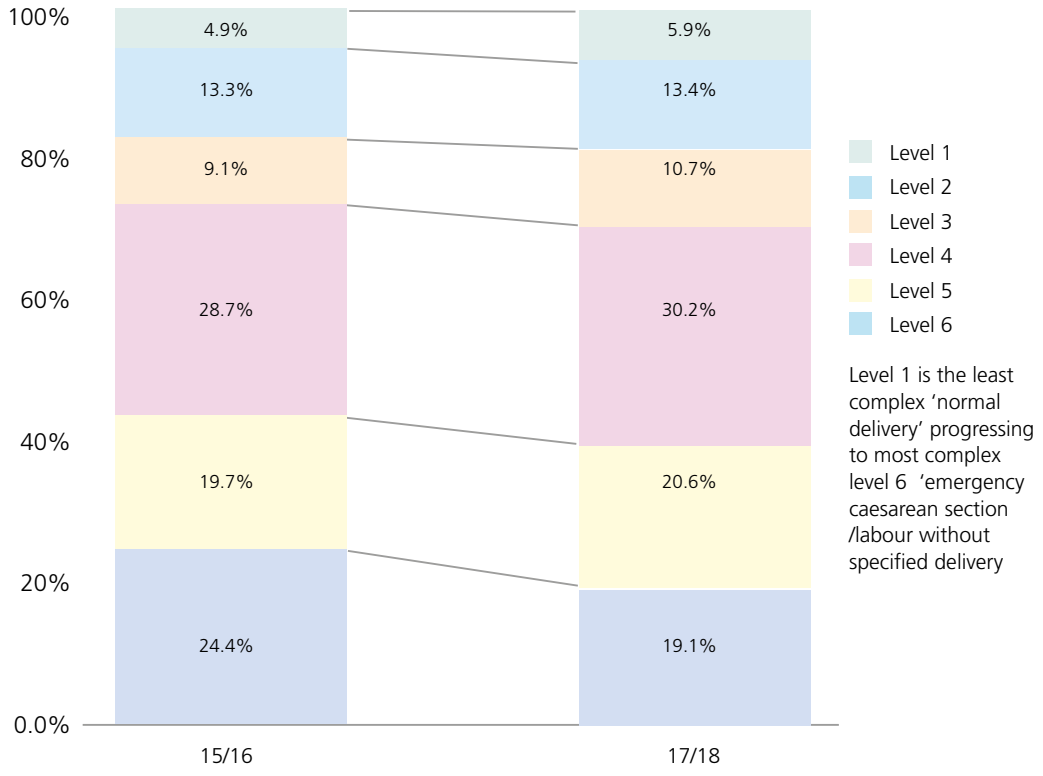

Figure 8: Analysis of casemix change on cost per birth[12]

Maternity services bear the greatest burden of litigation claims: obstetric claims make up 10% by volume but 50% by value of all NHS claims. Figure 9 shows total NHS Resolution CNST Payments have risen by an average of 12% per annum between 2005/06 and 2017/18. Continuing this trend will lead to payments of over £26 million by 2022/23 on behalf of Sussex and East Surrey; to mitigate against this the STP (and hence the LMS) must act to improve outcomes and safety to reduce claims.

11 Institute of Fiscal Studies Briefing Note BN215, Under Pressure? NHS Maternity services in England, 2017
12 Based on Reference Costs with 17/18 Expected HRG unit costs used in both 15/16 and 17/18

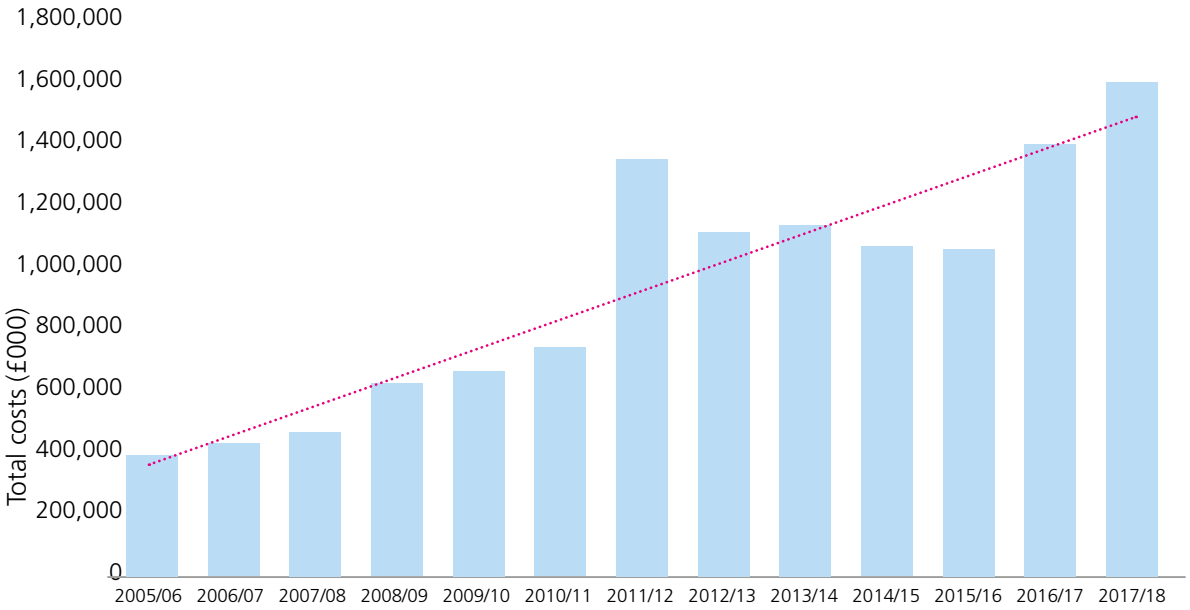

Figure 9: Total NHS Resolution CNST payments (2005/06 - 2017/18)

4.2 Health inequalities and unwarranted variation

Sussex & East Surrey has geographically the largest footprint in the country. The LMS faces an additional challenge of delivering a standardised, high quality service and reducing inequities of access and outcomes across a diverse population.

4.2.1 Unwarranted variation between providers

Recent GIRFT and CQC assessments have demonstrated unwarranted variation and gaps in services delivered at each site, effectively creating inequitable services for women accessing maternity services. A summary of the findings is shown below.

	Overall	Safe	Effective	Caring	Respon-sive	Well-led	
Royal Sussex (Sept 2018)	Good	Good	Outstand-ing	Good	Good	Good	• Spontaneous, unassisted vaginal delivery rate is below and induction rate is above England average • Elective c-section rate is high outside the upper control limit • Need processes for data quality and accuracy of patient records
Princess Royal (Sept 2018)	Good	Good	Outstand-ing	Good	Good	Good	
Conquest (March 2018)	Good	Good	Good	Good	Good	Good	• Worse then expected perinatal mortality rates • National outlier for maternal readmission rates • Improvements needed in bereavement rooms
Eastbourne	Not assessed						• Low FFT rate for intrapartum care and postnatal wards • High rate (15%) of spontaneous labours resulting in an emergency C-sections (primips) • Data quality issues around parity
East Surrey (Nov 2018)	Out-standing	Good	Good	Outstand-ing	Outstand-ing	Out-standing	• 1:32 midwife ratio (CQC October 2018), Trust now reporting 1:31 midwife ratio. • High rates of induction (improvement underway) • Purpose built birthing unit
St Richard's (Dec 2015)	Out-standing	Outstand-ing	Outstand-ing	Outstand-ing	Good	Out-standing	• Professional midwifery advocates: midwife ratio lower than national average • Staff morale low and midwives felt pressured • Capacity stretched with need to transfer patients between sites • Some delays for women waiting for induction and elective C-sections due to capacity issues • Data quality issues regarding parity
Worthing (Dec 2015)	Out-standing	Outstand-ing	Outstand-ing	Outstand-ing	Good	Out-standing	

Figure 10: Summary CQC & GIRFT findings[13]

Providers are working to implement local recommendations to reduce variation and are making demonstrable progress against CQC and GIRFT findings.

Building on this, providers and commissioners will need a continuous improvement mindset to ensure unwarranted variation is continually identified and acted upon. To help understand local variation better, the LMS is compiling a dashboard containing the key metrics from national and local sources. A summary is shown in Figure 11. Going forward, the LMS will be working to collect key metrics at site level testing reliability and validity of key measures with the purpose of increasing the confidence of the LMS in demonstrating impact and informing our approach. This will be used to inform local service improvements and track progress through discussion within partner organisations and the LMS Stakeholder Group and Programme Board. In this way, the LMS will use an evidence-based approach to identify areas of opportunity and target support to local partners.

13 Source: Trust CQC reports, accessed January 2019

KPI	BSUH	ESHT	SASH	WSHT	England	Source and date
Stillbirth rate (per 1000 live births)	4.02	3.69	3.71	3.86	3.93	MBBRACE 2016 rates, stabilised + adjusted
Neonatal mortality rate (per 1000 live births)	1.78	0.96	1.05	1.15	1.72	MBBRACE 2016 rates, stabilised + adjusted
Extended perinatal mortality rate (per 1000 live births)	5.72	4.65	4.75	4.99	5.64	MBBRACE 2016 rates, stabilised + adjusted
Maternal readmission rate	1.60%	0.10%	2.50%	3.10%	2.50%	NMPA clinical audit, 2017
Breastfeeding initiation rate	89%	75%	82%	80%	74%	Trust maternity dashboard (2017/18 average)
Smokers at delivery	4.70%	No data	7.80%	No data		Trust maternity dashboard (2017/18 average)
Smokers at booking	9%	18%	No data	13%	14%	National Maternity dash-board (avg Jan - Jun data)
Smoking cessation in pregnancy rate	58%	No data	10%	No data	20%	NMPA clinical audit, 2016
No. of live births (per year)	5,370	3,035	4,520	5,012		Trust maternity dashboard (2017/18 average)
Spontaneous vaginal deliveries	57%	58%	58%	60%		Trust maternity dashboard (2017/18 average)
Over all C-section rate	30.4%	27.8%	29.8%	28.5%	25%	Trust maternity dashboard (2017/18 average)
Operative vaginal delivery (ventouse & forceps)	11.9%	13.0%	12.3%	11.2%	12.6%	Trust maternity dashboard (2017/18 average)
Low intervention delivery	37.5%	35.8%	31.2%	No data		Trust maternity dashboard (2017/18 average)
Induction rate	25.8%	26.0%	36.6%	34.9%	28.0%	Trust maternity dashboard (2017/18 average)
Home birth rate (year avg)	4.4%	3.0%	1.5%	1.8%	2.3%	Trust maternity dashboard (2017/18 average)

Figure 11: Key outcome measures by trust

4.2.2 Health inequalities in local populations

Local populations vary substantially across the region in terms of socioeconomic status and deprivation, rurality, ethnic makeup, age distribution, disability, religion, sexual orientation, marriage and civil partnership. Some of these factors are associated with significantly worse maternal and fetal outcomes and poor access to care.

The case for reducing inequalities is well documented – there is a need for further local evaluation to assess the current differences and gaps in provision accurately, to develop effective local solutions.

	Avg index of deprivation	Rural popula-tion	Teenage women	Older women (>40)	BME women
Brighton & Hove	23.4	1.5%	0.5%	7.8%	13.8%
Coastal West Sussex	15.8	31%	0.5%	4.8%	3.1%
Crawley	17.8	0.3%	1%	4.4%	39.3%
East Surrey	11.2	20%	0.6%	5.6%	29.0%
Eastbourne, Hailsham & Seaford	18.0	22%	0.8%	4.0%	4.1%
Hastings & Rother	25.8	26%	1.5%	3.9%	2.0%
High Weald Lewes & Havens	12.1	76%	No data*	5.4%	5.8%
Horsham & Mid Sussex	8.3	25%	0.3%	5.7%	12.8%
England average	21.8	21%	0.7%	4.2%	23.6%

**Value suppressed for disclosure control reasons*

Group	Risk factors and challenges
Deprivation	Infant mortality rates are nearly double in the most deprived vs least deprived areas in England Increased risk of low and very low birth weight babies Poor access to care with late booking
Rural population	Higher risk of maternal morbidity Difficulties accessing antenatal care including late booking Reduced choice of birthplace offered
Teenage women	Infant mortality rates are nearly double in under 20s Higher rates of serious pregnancy complications incl. eclampsia, preterm birth, and low birth weight Higher risk of perinatal mental health disorders Poor long-term socioeconomic outcomes
Older women	Greater risk of maternal morbidity incl. gestational diabetes and eclampsia Higher risk of miscarriage, growth restriction and preterm birth Reduced choice of birthplace offered and greater rate of interventions
BME women	Infant mortality rates fro BME women are 1.5-2 times higher than for White women 2-5 times increased risk of maternal death

Figure 12: Prevalence of key disadvantaged groups by CCG, and key risks associated with each[14]

Delivering improvements in perinatal and maternal mortality and personalised maternity services will require engagement and outreach to 'seldom heard' groups. The LMS will work with MVPs to facilitate co-design of services to understand and meet the specific needs of these populations, giving all women a greater voice and involvement in their care. This collaborative relationship with each service user and her family is essential to improving safety and quality in maternity services, including morbidity and mortality.

4.3 Access to perinatal mental health services

Good quality, evidence-based perinatal mental health pathways improve access, lower mortality rates and reduce psychosocial needs in children, thereby improving long-term outcomes and delivering substantial cost savings to local health and social care systems.

An estimated 10% to 20% of women develop mental health needs during pregnancy or in the postnatal period, with up to 50% of cases undiagnosed. Figure 13 shows Public Health England's estimated annual caseload of perinatal mental health disorders, based on national prevalence rates.

14 Population demographics taken from Public Health England maternal and child health profiles. Key risks from ONS child mortality, MBRRACE maternal mortality and NICE evidence, accessed November 2018.

	Postpartum psychosis	Chronic serious mental illness	Severe depressive illness	Mild-moderate depressive illness	PTSD	Adjustment disorders and distress
Estimated prevalence	**2 per 1,000**	**2 per 1,000**	**30 per 1,000**	**100 – 150 per 1,000**	**30 per 1,000**	**150 – 300 per 1,000**
Total England	1,265	1,265	18,965	63,205 – 94,810	18,965	94,810 – 189,615
Brighton & Hove	10	10	90	290 – 430	90	430 - 860
Coastal West Sussex	10	10	140	455 – 680	140	680 – 1,360
Crawley	5	5	55	180 – 270	55	270 – 535
East Surrey	5	5	65	215 – 320	65	320 – 635
Eastbourne, Hailsham & Seaford	5	5	55	180 – 270	55	270 – 535
Hastings & Rother	5	5	55	170 – 255	55	255 – 510
High Weald Lewes & Havens	5	5	45	140 – 210	45	210 – 415
Horsham & Mid Sussex	5	5	75	240 – 355	75	355 – 710

Figure 13: Public Health England, estimated perinatal mental health burden, 2015/16

Sussex & East Surrey has a relatively high-risk population, with high rates of depression, common mental health disorders and severe mental illness in the general adult population, as shown in Figure 14. The high rates of teenage pregnancies in Crawley, Eastbourne, Hailsham and Seaford, and Hastings and Rother CCGs further increase the at-risk population in the region[15].

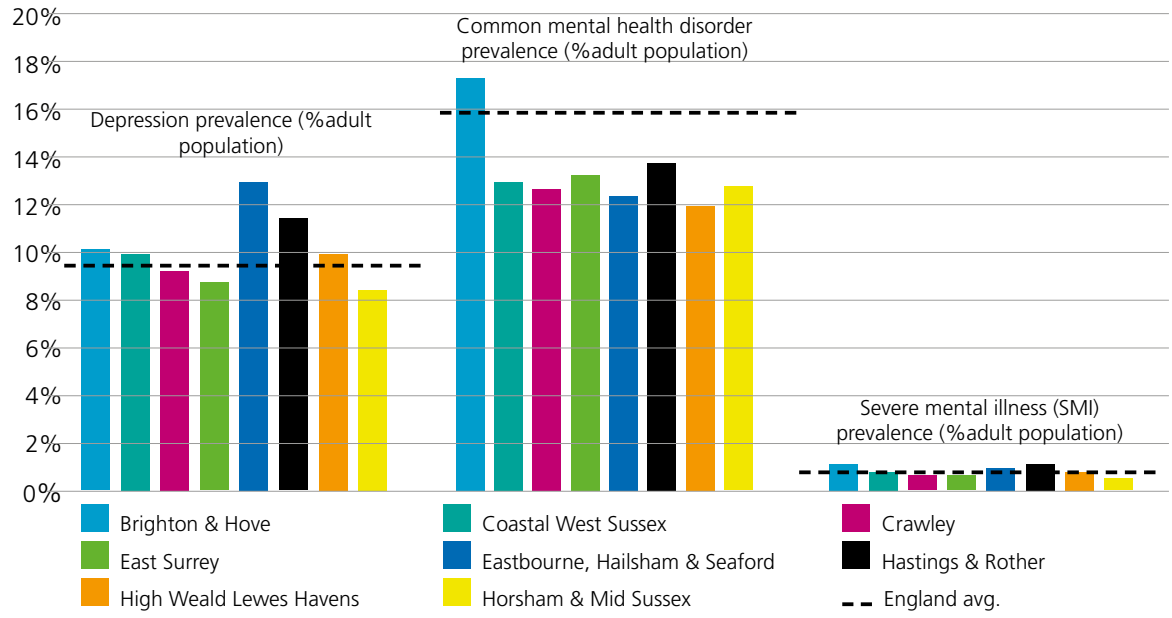

Figure 14: Baseline prevalence of mental health disorders within the local population

15 *Risk factors from Pearlstein T, Howard, M., Salisbury, A., & Zlotnick, C. Postpartum depression. American Journal of Obstetrics and Gynaecology (2009) 200(4):357-6*

4.3.1 Lack of universal provision of services

The Sussex & East Surrey Perinatal Mental Health (PNMH) Network has developed high-quality specialist local services using Wave 1 funding from the NHS England's Community Perinatal Mental Health Scheme. The source of continued funding (approximately £1.7 million) has not yet been confirmed.

Services are delivered by Sussex Partnership NHS Trust and a community-based team of 50 staff. They include home visits, psychological therapies, parent-infant psychotherapy and support to fathers and partners. Out of hours support is provided by existing adult mental health services. Additionally, an NHS England-commissioned inpatient Mother and Baby Unit is now open in Dartford, serving the Kent, Sussex and Surrey populations.

There is a gap in services for those with mild to moderate needs. Specialist teams do not have the capacity to see every service user with mental health needs, nor does every service user need such intensive or specialist support. Services such as continuity of carer for those identified at risk, increased postnatal support, including infant and family bonding programmes, facilitated self-help, peer support and Improving Access to Psychological Therapies (IAPT) programmes would help support women with less severe needs, potentially preventing them from needing specialist intervention. The LMS will work with the PNMH network and the wider health and social care system to ensure the full spectrum of support is available locally.

4.3.2 Missed opportunities for early detection and support

Access to specialist services relies on strong links between women and families and maternity services: these are not universally in place. In the LMS service user survey, 15% of women reported never being asked about their mental health, with a further 59% not asked at every appointment. These are missed opportunites to identify early signs and provide support for the family.

The LMS will work with providers and the PNMH network to understand the reasons for this, identifying and developing solutions to address potential gaps in training or changes to policies and proformas in order to ensure women are consistently asked about their mental health and well-being. Those women who are identified as being vulnerable or at risk of developing perinatal mental health issues should be offered targeted support along with continuity of carer, with partner organisations working together to meet their needs.

4.4 Maternal experience

Women and their families are at the heart of the vision for maternity services. This means ensuring they experience a caring, supportive and personalised pregnancy journey.

Evidence suggests women experience better outcomes when they are more involved in their own care[16]. Additionally, for many women, pregnancy is the first time they have had sustained contact with health services – this provides a unique opportunity to support lasting, positive lifestyle changes. Improving women's experiences can therefore deliver long-lasting benefits for the well-being of families and will enable improvements in the other three core outcomes.

The table below shows the priority areas for women in Sussex & East Surrey, identified through an online survey of nearly 1,000 users. The LMS will be sharing full survey results upon completion of Phase 2. To mitigate low representation amongst certain disadvantaged groups in Phase 1, targeted engagement has been planned to reach these groups in Phase 2 (See Section 9.1.1.)

16 This includes reduced risk of stillbirths and preterm labour and lower intervention rates

Theme	Supporting evidence
Improved choice of birthplace	• 11% were offered no choice of birthplace (national average 14%), with considerable variation by demographic group • Nearly 50% of women were offered a home birth but only 15% were offered a midwife-led unit • 58% stated more choice was very important to them in the future • 65% would be interested in a midwife-led unit in future pregnancies
Continuity of Carer	• 35% of women saw a different midwife at each contact (vs 40% nationally) and 24% saw a different health visitor • 30% of women felt seeing multiple midwives negatively impacted their care • 75% reported it as being important to them in future pregnancies
Feeding support	• 33% of women were unsatisfied with information they were given • 47% reported receiving inconsistent advice

Table 2: Themes emerging from service user engagement

These themes are based on the views of a self-selecting sample and may not represent the needs or experience of women from minority groups. The LMS has identified some key 'seldom heard' groups of people to engage with via focus groups. Building relationships with these communities early will enable ongoing engagement and future co-design of services that reflect the full range of local needs. Furthermore, it is important that Maternity providers create and sustain communication and information sharing pathways with the Healthy Child Programme (HCP) services within their area to support the ongoing health and well-being of women in the antenatal period.

4.5 Site-level volumes and staffing

Table 3 shows the site-level breakdown of births, consultant cover and midwife to birth ratios. All trusts have recently been assessed by Birth Rate Plus and, where workforce gaps were identified, they are developing plans to address them. When comparing weekly hours of consultant cover with national standards[17], all sites meet minimum levels, however several sites have fewer than 2,500 births.[18]

Site	# of Births† (17/18)	Consultant Cover (hours/week)	Midwife to Birth Ratio
St Richards (WSHT)	2,596	80	29:1
Worthing (WSHT)	2,416	80	29:1
Royal Sussex (BSUH)††	3,011	60	30:1
Princess Royal (BSUH)††	2,359	40	30:1
Eastbourne (ESHT)†††	294*	N/A	28:1
Conquest (ESHT)†††	2741*	72	
East Surrey (SaSH)	4,520	88	31:1

† Trust Maternity Dashboards October 2018: WSH report women delivered;other trusts show live births
†† Estimated using 18/19 M6 YTD site data and 17/18 Trust births
*††† Site-level data not available at time of writing * Includes unit and community births*

Table 3: Site-level volumes and staffing

For units below 2,500 births per annum, the Royal College of Obstetrics and Gynaecology recommend units continually review staffing to ensure it is adequate for local needs. They do not provide a minimum standard for consultant cover for units below 2,500 births per annum.

17 Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour; Royal College of Obstetrics and Gynaecology, 2007
18 Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour; Royal College of Obstetrics and Gynaecology, 2007

Category	Definition (births/year)	Consultant presence (year of adoption)			Specialist trainees (n)
		60 - hour	98 - hour	168 - hour	
A	<2500	Units to continually review staffing to ensure adequate based on locals needs			1
B	2500-4000	2009	-	-	2
C1	4000-5000	2008	2009	-	3
C2	5000-6000	Immediate	2008	2010	
C3	>6000	Immediate	Immediate if possible	2008	

Table 4: Proposed obstetric staffing targets, 2007–2010 (adapted from The Future Role of the Consultant)

5 Vision: A changing approach to maternity services

The National Maternity Review signalled a paradigm shift in maternity services and acknowledges the critical importance of maternal involvement in driving improvements in safety and quality. Many of the recommendations aim to strengthen links with women, placing families at the heart of maternity services.

The LMS will embody this principle to deliver transformative change within the Sussex & East Surrey region. The end objective is to empower and enable all women to make real choices about their care, supported by collaborative relationships with healthcare staff, access to care in the community, and ultimately services which are co-designed to meet their needs.

5.1 Choice and personalisation

Women and their families will be empowered to make real, informed, choices about their maternity journey and shape their experience to suit their circumstances, through use of personalised care plans, provision of high quality unbiased information and increased discussion (e.g. birth choices clinics or specialist midwives). Teams will ensure women are given chances to make decisions at every stage of their care, discussing the implications and acknowledging any limitations due to medical reasons.

Maternity services will maximise opportunities to respect and act on women's preferences at every stage, as long as it is safe to do so. Where it is not, teams will prioritise upfront and transparent communication with families to ensure they continue to feel consulted and involved.

A key element of choice is birth setting. Each place is reviewing the choice available to women and will consult the LMS as proposals are developed to ensure all women have access to home, midwife-led and labour ward births.

Enabling and respecting choice is critical to ensuring women and families feel involved in their care. It is only through genuine engagement with women will maternity services be able to improve safety and reduce mortality, reduce inequalities and improve early identification and support of perinatal mental health.

5.2 Collaborative relationships with maternity teams

Fostering strong, respectful and trusting relationships between women, families and maternity teams are essential to supporting and enabling choice. Continuity of Carer (CoC) models aim to provide women with a small team of four to six midwives to provide care for the antenatal, intrapartum and postnatal periods, and to advocate for their wishes. These models show evidence of improving safety and reducing the risk of adverse outcomes, increasing rates of home births and improving experience[19]. Sussex and East Surrey midwifery profile shows an aging workforce with many part time staff requesting fixed working patterns and will require ongoing workforce planning and transformation, along with in depth financial modelling to support this outcome.

5.3 Access to care in the community

A key component of the vision for maternity services is community-based care as the default. Community hubs will bring together providers across a range of services including prevention and pre-conception care, maternity services including perinatal mental health, postnatal, newborn, early years and child health. These hubs will provide a one-stop service for women and families to access the full spectrum of health and social care services, improving access to care and engendering a life course approach to maternal and child health. Easily accessible local services will foster deeper relationships between women and providers, facilitating closer working between partner organisations and building relationships with local communities. Maternity providers will share information and link with Universal Healthy Child programme Services in the community to support the ongoing health and well-being of women in the antenatal period. Gaps in community hub provision will be reviewed at STP level with key partners and Estate leads.

19 *J. Sandall, Midwife.led continuity models versus other models of care for childbearing women, Cochrane Systematic Review, 2016*

5.4 Services co-designed with women and families

For women and their families to be at the heart of maternity services, their voices and needs must be incorporated into ongoing service development and improvement, using a co-design approach.

Co-design is a way of working that enables providers, women, carers and communities to come together in equal partnership. It engages groups of people at the earliest stages of service design, development and evaluation[20]. Effective co-design needs to be based on the views of all women who use services; we will establish a baseline service user view of maternity services that incorporates all voices across Sussex and East Surrey. The LMS will support the MVPs to actively reach out to hard to reach groups to ensure development of services that meet the full range of needs of their local population. There is more detail in Section 9.1 about how the LMS will work with organisations to ensure co-design is embedded within the transformation programme.

6 System benefits delivered through maternity transformation

Delivering the future vision for maternity services will have substantial short and long-term benefits for the Sussex & East Surrey health and social care system:

- ✔ improved safety and outcomes
- ✔ improved population health
- ✔ better staff and user satisfaction
- ✔ increased service sustainability
- ✔ better value maternity services

20 Definition from Coalition for Collaborative Care (2016) A co-production model; Five values and seven steps to make this happen in reality,

6.1 Clinical outcomes and population health

Putting a spotlight on safety will improve outcomes for women and families. Full implementation of the Saving Babies Lives care bundle has been associated with a 20% reduction in stillbirths and meeting national target trajectories for reducing perinatal mortality will save 51 lives/year by 2025. Improving fetal monitoring (part of Saving Babies Lives Care Bundle) and implementing the recommendations from Each Baby Counts will reduce avoidable morbidity and lifelong disability associated with brain injury around the time of birth – improved care could lead to a better outcome in up to 71% of cases[21].

Prioritising prevention services and maternal health will improve overall population health, reducing health inequalities and giving every child a healthy start in life. Maternal smoking is associated with a 47% increase in risk of stillbirth[22], a 27% increased risk of pre-term birth and an 82% increased risk of a low birth weight baby[23] as well as increased risk of congenital abnormalities of the heart, limbs and face. What happens during pregnancy, during birth (including birth injury*) and early years also impacts on an individual's risk of long-term ill health, such as obesity, substance misuse, risk of heart disease, dental decay and poor mental health, and can compromise healthy emotional, cognitive and physical development. Many of the increased risks stem from deprivation and health inequalities: tackling these will provide significant benefits to individuals, families and the system.

Focusing on maternal involvement will also have a significant impact on outcomes. Women who receive continuity of midwife-led care are 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks. They are also 24% less likely to experience pre-term birth[24].

21 Royal College of Obstetricians & Gynaecologists. Each Baby Counts 2018 Progress Report, November 2018
22 Maternal smoking and the risk of still birth: systematic review and meta-analysis; Takawira C Marufu, Anand Ahankari, Tim Coleman and Sarah Lewis BMC Public Health 2015, 15:239 doi:10.1186/s12889-015-1552-5
23 Royal College of Physicians. Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010
24 J. Sandall, Midwife.led continuity models versus other models of care for childbearing women, Cochrane Systematic Review, 2016

**Birth injury includes maternal and baby injury.*

6.2 Maternal and staff experience

The experience and involvement of women and families is critical to this transformation programme as detailed in Sections 4.4 and 4.5 Improved experience, meaningful involvement and trusted relationships will all contribute to system benefits through improved outcomes, greater uptake of lifestyle messages and positive change, and improved health and well-being for women and families.

Much has been said about the experience of women. We also need to recognise the benefits to maternity staff that will be delivered through this transformation programme. The ability to form personal, collaborative relationships with women and follow them through their journey is associated with increased staff satisfaction[25]. The focus on skills development, shared learning and potential for new ways of working with creation of new roles or increased responsibility, will allow all staff groups to pursue their interests and ideas and collaborate with colleagues from across organisations. Additionally, stillbirths and adverse outcomes are known to negatively impact staff well-being, with psychological trauma, anxiety and fear of disciplinary action and litigation all being experienced. Improving safety will therefore contribute to improvements in staff wellbeing[26]. It is however recognised that Continuity of Carer models have in the past led to high levels of burnout in midwives and the LMS recognises the importance of ensuring good staff engagement, with midwifery teams developing models that provide higher levels of satisfaction and reduce the risk to the well-being of midwives.

6.3 Service sustainability, resilience and value

The national Maternity Transformation Programme aims to develop sustainable, fit for the future maternity services, which deliver the best value for women and the system.

Improvements in safety will lead to a significant short and long-term cost saving for local providers. Comprehensive investigation of each stillbirth is estimated to cost £1,200 - £1,800 and women who have experienced a previous stillbirth are likely to utilise more health care services with an increased cost per birth of £2,100 - £3,751[27]. Nearly 40% of women who experience a stillbirth reduce their working hours and for those returning to work productivity is estimated to be between 26 – 63% of normal[28] – this represents a significant indirect cost to families and an economic cost to the system, which will be avoided through improved perinatal mortality rates. Additionally, improved safety and better relationships with users will help to reduce litigation costs, which represent a significant expenditure for maternity services – obstetric claims represent 10% by volume but 50% by value of all NHS claims[29].

Perinatal mental health disorders are estimated to cost the national health and social care system £1.2bn annually through care provided to both women and child[30]. The total long-term costs to society are estimated at £8.1 billion for each one-year cohort of births – this is the equivalent of just under £10,000 for every birth in the country and 72% of the costs are related to the child. Improving maternal mental health and well-being therefore represents an opportunity to dramatically reduce long and short terms costs related to both mother and child.

In the short term, increased collaboration through the LMS programme will allow partners to identify both efficiency opportunities and cost pressures. Moving care closer to home, reducing intervention rates and improving overall health and well-being will provide opportunity to reduce costs per birth and release capacity within stretched labour wards and in-hospital facilities. Women in midwife-led continuity models are less likely to use epidurals, have instrumental or operative vaginal births – this reduces the cost per birth for these women and hence large-scale roll-out of Continuity of Carer may be associated with cost savings across the system[31].

25 Royal College of Midwives, Continuity of Carer: an update, 2017

26 A. Heazell, Stillbirths: economic and psychosocial consequences, The Lancet, 2016

27 H. Mistry, A structured review and exploration of the healthcare costs associated with stillbirth and a subsequent pregnancy in England and Wales, BMC Pregnancy Childbirth 2013

28 A. Heazell, Stillbirths: economic and psychosocial consequences, The Lancet, 2016

29 National estimates from NHS Resolution CNST Maternity Incentive scheme.

30 Centre for Mental Health, LSE Personal Social Services Research Unit. The costs of perinatal mental health problems – report summary (2015)

31 J. Sandall, Midwife.led continuity models versus other models of care for childbearing women, Cochrane Systematic Review, 2016

In the long term, the focus on prevention in early life will accumulate significant benefits for women and their children. Reducing health inequalities and optimising maternal physical and mental health will have long-term benefits:

- improved health and quality of life
- reduced demand
- reduced cost to health and social care services.

The first few years of life (including during fetal development) are also critical for readiness to learn, educational achievement, income and economic status[32]. Improving maternal health can therefore deliver significant long-term economic benefits and is key to reducing socio-economic inequality and unlocking a healthier and more productive future population.

7 Key service changes required

7.1 Summary of recommendations

To define the work required to deliver the vision, the LMS has conducted an evaluation of current services with a gap analysis against national recommendations. Together with a review of local best practice, this has identified several service improvement opportunities to help improve the four core outcomes.

Providers are responsible for most of these, including national best practice guidance and targeted local opportunities (identified through GIRFT and CQC assessments). Commissioners need to work with providers to assess the trajectories and impact of quality improvement projects, setting and monitoring key metrics and reviewing contractual arrangements needed to facilitate improvement.

Figure 15 shows a summary of the key provider interventions required to deliver the four outcomes and the role of the LMS in supporting these. Further detail is described in Figure 16 - Figure 19 on each recommendation, including the challenge addressed, the opportunity within each trust and the involvement of key stakeholders. These opportunities represent a point in time assessment agreed by providers and commissioners and remain under review as we continue to improve the quality of services. For simplification Providers in this context refers to not only the four acute trusts but also community trusts, mental health providers, public health providers and primary care. Commissioners in this context refers to not only clinical commissioning groups, but all commissioners including NHS England and local authorities.

32 C. Larson, Poverty during pregnancy: Its effects on child health outcomes, Paediatric Child Health, 2007

Provider/commissioner led interventions		Role of the LMS		
Safety & perinatal mortality	Implement Saving Babies Lives Care Bundle Reduce maternal smoking at delivery rates to 6% and optimise weight management Ensure safe staffing levels with sufficient midwife: birth ratios and consultant cover and capacity Include ATAIN, Each Baby Counts, Making Every Contact Count and CTG In staff training Investigate all incidents and circulate feedback at a system level	**Co-designing services with women and families** **Empowering women and families to have a voice in their own care, through the use of Maternity Voice Partnerships and targeted engagement with seldom heard groups**	**Supporting local organisations to deliver change** **Enabling continuous quality improvement and robust transformation planning by evaluating long-term and/or system implications, linking local organisations central bodies and aligning system priorities and plans**	**Leading system-wide collaboration & transformation** **Facilitating meaningful collaboration across health and social care partners by creating a culture of joint working, removing structural barriers and supporting implementation of joint service improvement initiatives**
Health inequalities & unwarranted variation	Implement GIRFT & CQC recommendations Monitor outcome and intervention rates to identify variation and act to address these Provide specialist pathways and support services for known disadvantaged groups Adopt an interoperable digital maternity information system			
Perinatal mental health	Provide 24/7 access to PNMH advice and guidance, incl. emergency assessments Deliver joint mental health and obstetric care Ensure mental wellbeing is assessed at each contact Provide support services for at-risk women Include PNMH topics within mandatory training, including mental health crises			
Maternal experience	Develop personalised care plans, including discussion of choice of birthplace Develop and implement a consistent, digital experience for women to access their maternity record and information. Offer women option of home, midwife-led and labour ward births Implement Continuity of Carer pathways to meet national trajectories Provide specialist feeding staff and training Incorporate patient feedback into service improvement initiatives			

Figure 15: Summary of provider/commissioner opportunities and the role of the LM

Improvement opprtunities: safety & perinatal mortality

Recommended intervention	Challenge to be addressed	IMPROVEMENT OPPORTUNITIES BSUH	ESHT	SASH	WSHT	System roles in improvements LMS	Provider	Commissioner	STP	PNMH network	Neonatal ODN
Operationalise Saving Babies Lives care bundle	Meeting national trajectories to reduce perinatal mortality	◐	◐	○	◐	I	AR	C			I
Offer smoking cessation to reduce smoking at delivery rates to 6%	High maternal smoking rates within local population	●	●	●	●	C	R	AR	I		
Support healthy weight and offer specialist maternal weight management services	Increasing prevalence of maternal obesity	●	●	●	○	I	R	AR	I		
Ensure safe staffing levels and workforce capacity for all groups	Sufficient workforce to deliver maternity services in line with Better Births	●	●	●	●	I	AR	C	I		
Include ATAIN, Each Baby Counts, Making Every Contact Count and CTG in staff training and competence assessment	All staff need to have capabilities and competence to implement best practice guidelines	◐	◐	◐	◐	I	AR	C	I	C	C
Disseminate learnings and corrective actions system-wide in LMS safety forum	Lack of system-wide sharing of lessons learnt from adverse events	●	●	●	●	A	R	RC	I	I	I
Facilitate and optimise integrated working across organisations	Silo working between partner organisations	●	●	●	●	A	R	R	I		C

● Definite opportunity ◐ Potential opportunity ○ No opportunity

Figure 16: Opportunities for improving safety & perinatal mortality with who's Responsible, Accountable, Consulted and Informed (RACI)

Improvement opportunities: health inequalities & unwarranted variation

Recommended intervention	Challenge to be addressed	IMPROVEMENT OPPORTUNITIES: BSUH	ESHT	SASH	WSHT	System roles in improvements: LMS	Provider	Commissioner	STP	PNMH network	Neonatal ODN
Implement GIRFT & CQC recommendations	Specific areas of work identified within each provider	●	●	◐	●	I	AR	C			
Monitor outcomes and intervention rates to identify opportunities to improve outcomes and experience	Variation in interventions, outcomes and experience across providers	◐	◐	◐	◐	C	AR	R	I	I	I
Provide specialist pathways and support services for known disadvantaged groups	Diverse local populations with poor access and outcomes for disadvantaged groups	◐	◐	○	◐	C	R	A		I	I
Conduct targeted engagement with hard to reach groups and develop interventions to meet their needs	Worse outcomes seen in hard to reach groups	●	●	●	●	R	R	AR	I	C	C
Implement interoperability of digital maternity services	Siloed digital systems limit sharing of information	●	●	●	●	R	AR	C	C	I	C
Define a single service specification, including outcomes-based commissioning model and standardised pathways	Unwarranted variation between local providers	●	●	●	●	A	R	R	I	C	C
Review opportunities for shared services/ joint service improvement initiatives	Need to ensure delivery of best value care and identify efficiency opportunities	●	●	●	●	A	R	R	I	C	C

● Definate opportunity ◐ Potential opportunity ○ No opportunity

Figure 17: Opportunities to improve health inequalities & unwanted variation with who's Responsible, Accountable, Consulted and Informed (RACI)

Improvement opportunities: perinatal mental health

Recommended intervention	Challenge to be addressed	IMPROVEMENT OPPORTUNITIES				System roles in improvements					
		BSUH	ESHT	SASH	WSHT	LMS	Provider	Commissioner	STP	PNMH network	Neonatal ODN
Provide 24/7 access to PNMH advice and guidance, incl. emergency assessments for moderate/severe PNMH including post-partum psychosis	Frontline services need access to MH specialists out of hours in case of emergency	◐	◐	◐	◐	I	AR	CR	I	C	
Improve joined up mental health and obstetric care provision	High occurrence of at-risk women in population with variation in access	○	◐	○	○	I	A	R	I	R	
Ensure mental wellbeing is assessed at each contact	22% of local women reported being asked consistently	●	●	◐	●	C	AR	I		C	
Include PNMH topics within mandatory training, including mental health crises	All staff need to be able to identify at-risk women to be able to provide support	●	◐	○	◐	C	AR	I		C	
Review PNMH pathways and access to mild/moderate support to identify gaps and develop solutions	PNMH network aimed at those with severe needs with potential gaps for mild/ moderate needs	◐	◐	◐	◐	C	R	AR	I	C	
Facilitate integrated working between trusts, community and specialist mental health teams and social workers	Need for more joined up care across multiple organisations	●	●	●	●	C	R	I		A	
Raise awareness to reduce stigma around PNMH issues to facilitate greater reporting	Social stigma around PNMH reduces women's ability to ask for help	●	●	●	●	A	C	C	I	R	

● Definate opportunity ◐ Potential opportunity ○ No opportunity

Figure 18: Opportunities to improve perinatal mental health with who's Responsible, Accountable, Consulted and Informed (RACI)

Improvement opportunities: maternal experience

Recommended intervention	Challenge to be addressed	Improvement opportunity or current gap in services				Ownership (RACI chart)					
		BSUH	ESHT	SASH	WSHT	LMS	Provider	Commissioner	STP	PNMH network	Neonatal ODN
Develop personalised care plans	Need to tailor care to meet individual needs and empower women to have real choice	○	○	○	○	C	AR	C		I	
Offer women option of home, midwife-led and labour ward births	Only 15% were offered a midwife-led unit in Sussex & East Surrey	●	◐	○	◐	R	R	A	C		
Operationalise Continuity of Carer pathways to meet national targets	35% of women saw a different midwife each time and 30% felt this negatively impacted their care	●	●	●	●	C	AR	R	I	I	
Evaluate initial rollout of Continuity of Carer to inform trajectories and targets	Continuity of Carer is a large scale change with potential unintended consequences	●	●	●	●	R	AR	R	C	I	
Develop and implement a consistent, digital experience for women to access their maternity record and information	Need to tailor care to meet individual needs and empower women to have real choice	●	●	●	●	R	AR	C	C		
Improve consistency of communication around feeding support and advice	33% of women were unsatisfied with the support they received	○	◐	○	◐	C	AR	C	I		
Optimise the use of community hubs to provide services closer to home	Need to deliver services that work around women and their families	◐	◐	◐	◐	R	R	A	C	C	I
Use MVPs and targeted engagement to co-design services with women	Need to design services that meet the needs of women and families	●	●	◐	●	C	AR	R	I	C	C

● Definate opportunity ◐ Potential opportunity ○ No opportunity

Figure 19: Opportunities to improve maternal experience with who's Responsible, Accountable, Consulted and Informed (RACI)

8 Financial Implications

As described in Section 4.1.3, the costs of maternity care are rising. A do-nothing trajectory is associated overall with a financial pressure of £6 - £8million in five years' time. The main driver for this is increasing CNST contributions, with only minor contributions from growing birth rates, increasing complexity and inflation.

The case for improving quality is clear. In aggregate, poor perinatal outcomes lead to very significant costs to the system. CNST maternity contributions totalled £21million across Sussex and East Surrey providers in 18/19. Provider contributions take account of the value of negligence claims brought against provider organisations, and the value of known outstanding claims[33]. Whilst increases in average negligence payments may make absolute reductions in CNST contributions difficult, improving outcomes and avoiding adverse incidents can be expected to reduce CNST contributions relative to a counter-factual 'Do Nothing' scenario.

Ongoing care costs for Perinatal Brain Injuries (PBI) are significant but currently poorly understood. Based on national estimates, PBI incidence in Sussex and East Surrey may be around 100 births pa[34]. Total costs of care following PBI are difficult to establish. Conditions resulting from PBI include Cerebral Palsy, Intellectual Disability, deafness and blindness, and can lead to significant and continued costs throughout the life of the individual. The value at stake in avoiding such incidents is significant in every sense.

There is evidence to link the individual quality improvements described in this plan to improving perinatal outcomes, but the balance of schemes that reinforce one another versus having an additive benefit is complex. Furthermore, the link between improvements in quality of care and STP system costs is also complex; improvements in quality provide the opportunity for financial benefits for partners, but not with certainty.

In response to this uncertainty, and to optimise the financial sustainability of the LMS, partners should:

- Collaborate to ensure providers consistently secure any available CNST discounts relating to maternity contributions
- Require that subsequent investment proposals are rigorous and demonstrate an increase in the value per pound of healthcare spend
- Explore costs relating to PBI and use the insights to appraise proposed investments to reduce rates of PBI

As investment in maternity services included in 2019/20 planning guidance and the NHS Long Term Plan are not known at the time of writing, the LMS Plan is not a pre-commitment to increased levels of spend but instead a translation of the national standard for local purposes subject to future business cases for any increased funding.

There are a number of key investment drivers to be considered:

- Birth Rate Plus: Meeting Birth Rate Plus ratios by increasing the number of band 5-6 midwives
- Continuity of Carer: Increasing the number of women on the Continuity of Carer pathway
- Serial Growth Scanning: Additional band 7 ultrasonographer capacity to support serial growth scanning for women with 1 or more risk factors
- Specialist Perinatal Health

33 Basis for provider contributions from 19/20 CNST contribution notification letter
34 https://www.imperial.ac.uk/news/183359/incidence-brain-injury-babies-estimated-first/

Birth Rate Plus, Continuity of Carer and Serial Growth Scanning are critical to delivering best practice care and therefore driving improvements in safety and quality. Each of these has evidence linking them to significant improvements in quality[35,36,37] and therefore has the potential to contribute to cost savings across the system via reductions in litigation claims and CNST premiums. Additionally, reductions in intervention rates can further reduce overall cost per birth. As these interventions are worked up in more detail, their ability to improve quality and reduce claims should be considered along with the additional value to women of achieving better outcomes.

More work is needed to understand the differential impacts of these investment drivers in different parts of the STP. Investments will need to demonstrate significant value to women, and will need to be tested for affordability and considered alongside demand for investment from other services. Due process will need to be followed to identify funding for various strategic investments from sources including tariffs, additional local funding and providers.

In this context, therefore, opportunities to improve services within current resources must be maximised and investment targeted at initiatives which can improve quality and where possible reduce costs.

The large majority of recommendations and service improvement opportunities shown in Figure 16 - Figure 19 are incremental and will deliver modest improvements over the next five years. These will be progressed by partner organisations within their transformation plans, acknowledging some variation in investment required due to the different context of each maternity service.

9 Role of the LMS

The National Maternity Review has set a clear direction for transformation while allowing scope for local services to innovate and design local, fit-for-the-future maternity services, working across boundaries and in partnership with women and families.

Figure 20 shows the key roles of the LMS in supporting local maternity transformation, and the priority areas within each.

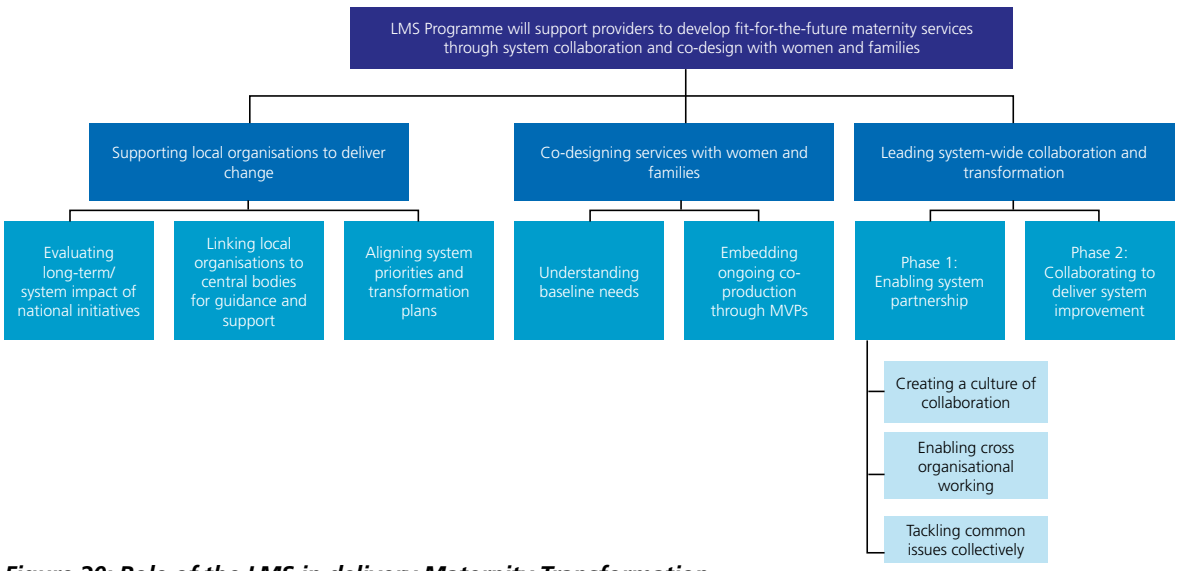

Figure 20: Role of the LMS in delivery Maternity Transformation

35 1:1 midwife care in labour is recommended under RCOG and NICE guidelines and is associated lower C-section and operative delivery rates, shorter length of labour and reduced risk of postnatal mental health disorders (RCM Evidenced Based Guidelines for Midwifery Led Care in Labour, 2012)

36 Midwife-led continuity of carer is associated with reduced risk of stillbirth and fetal loss, pre-term birth, reduced intervention rate and increase in normal births (J. Sandall, Midwife.led continuity models versus other models of care for childbearing women, Cochrane Systematic Review, 2016)

37 Fetal Growth Restriction is the biggest risk factor for stillbirths and early detection through growth scanning has been shown to significantly reduce stillbirth risks by allowing timely delivery of at risk babies.

9.1 Co-designing services with women

The voice of women and families is a core principle running through the Maternity Transformation Programme, enabling improvements in safety and quality. The LMS will play a critical role in bringing together users and providers, identifying system level trends and opportunities and facilitating large-scale consultation to guide development of maternity services that meet the needs of local populations.

9.1.1 Understanding current service user needs

Gaining a baseline understanding of engagement and women's views has been an early priority for the LMS, with an extensive service user engagement exercise run through 2018. Phase 1 consisted of an online survey of nearly 1,000 women in West Sussex and East Surrey and early focus groups with gypsy and traveller communities. Phase two, (November 2018 – March 2019) will roll this survey out to women in East Sussex, with further focus groups and outreach to seldom heard groups utilising the expertise and contacts of people and organisations already working in those communities. Target groups include bereaved families, women who are deaf or hard of hearing, refugee families, gypsies and travellers, Black and Minority Ethnic, parents whose first language isn't English, teenage/ young parents and parents with learning disabilities. On completion of this service user engagement exercise, the LMS will use insights gained to focus on the long-term involvement and co-design of services with women. The online survey will also be repeated at the end of 2020 to review progress and set the ongoing priorities within the LMS.

9.1.2 On-going co-production through Maternity Voices Partnerships

Maternity Voices Partnerships (MVPs) (formerly Maternity Services Liaison Committees) provide a forum for co-design, ensuring women are actively involved in service development and providing services with real-time feedback and detailed insight into the experience of women and families. MVP chairs also sit on the Stakeholder Group to bring the voice of women into the core business of the LMS. MVPs will be used as the primary long-term forum for service user engagement within the LMS.

MVPs in Brighton and Hove, East Sussex, Mid Sussex and East Surrey are well established. West Sussex is in the process of setting-up an MVP with the support of the LMS, learning from the experience and successes of the other sites.

Appropriate funding is essential to delivering the full value of MVPs. However, of the established MVPs, Brighton and Hove is funded by commissioners, with the other three relying on members to volunteer their time and expertise. To mitigate this real risk to the sustainability and effectiveness of the local MVPs, the LMS programme is providing £20,000 in funding to be shared across the four currently unfunded MVPs This is to remunerate chairs and enable MVPs to proactively engage with traditionally seldom heard communities.

The LMS will ensure they play a continued role in the development of maternity services by working with MVPs and commissioners to agree a sustainable source of funding for future years. Additionally, the LMS will provide ongoing ad-hoc support to the MVPs and host bi-monthly chairs meetings to facilitate shared learning and collation of system-wide trends.

MVPs will be responsible for the long-term engagement of their local populations, and the LMS will support the set-up of this. Effective co-design needs to be based on the views of all women who use services, not just those who readily articulate their views. Building on the relationships established during the baseline engagement, MVPs will be supported to identify their local target groups and run tailored programmes of engagement and outreach to bring the views of these women into service development.

9.2 Supporting organisations to deliver local change

Providers (working with commissioners) are responsible for delivering most of the improvements, as described in Section 7.1, and are successfully progressing many of these. However, resource constraints can limit the scale of achievable transformation when priority is given only to the most pressing issues or perceived quick wins.

When this happens, grassroots initiatives may struggle to gain traction and deliver their full potential. The LMS enables continuous quality improvement and robust transformation planning by evaluating long-term and/or system implications, linking local organisations with central bodies and aligning system priorities and transformation plans.

9.2.1 Evaluating long-term and system impact

Key recommendations from the National Maternity Review require large-scale changes in the organisation and delivery of care – e.g. implementing a midwifery caseloading model (under Continuity of Carer), delivering care closer to home using community hubs and offering the full range of birthplace options to all women. Success requires a robust transformation plan and a thorough grasp of the long-term and/or system implications, including workforce, activity, and income and expenditure.

The LMS will help carry out this detailed design, providing trusts and commissioners with a clear understanding of the requirements and implications, in order to inform their transformation planning. Where local services need investment to implement critical service improvements, this will remain a decision for partner boards and governing bodies. Table 5 below shows a summary of the key work the LMS will undertake.

Recommendation	Supporting work of the LMS
Continuity of Carer	• Workforce analysis and planning to define the additional requirement needed under a midwifery Continuity of Carer model • Evaluation of the initial roll-out in terms of outcomes, staff and patient experience and finances • Definition of achievable trajectories for the roll-out to meet national target of majority of women on CoC pathways by March 2021
Use of community hubs	• Scoping the work required to set up hubs and the requirements for providers, commissioners and local authorities • Patient flow and activity analysis to ascertain the optimum number, capacity and location of hubs • Liaising across providers to define and coordinate the potential services offered within hubs
Choice of birthplace	• Reviewing existing services and mapping current choices offered to women to identify potential gaps • Consultation with locations on proposals to enhance level of choice to women locally

Table 5: Supporting detailed work to be undertaken by the LMS

9.2.2 Linking local organisations to central bodies

Local organisations need access to support, advice and guidance from central bodies (including NHS England, NHS Improvement, Health Education England and Public Health England) but often find it difficult to access this in a timely way. The LMS will bridge this gap, facilitating ongoing input and collaborative working in priority areas.

Representatives of the NHS England South Maternity Clinical Network sit on the LMS Stakeholder Group, allowing organisations to question and develop plans in line with the most up-to-date national guidelines and priorities. Close working with regional and national teams will enable the LMS (and partner organisations) to connect with Early Adopters and learn from their experience.

9.2.3 Aligning system priorities and transformation plans

Maternity services have seen many national initiatives and guidance[38] released following the National Maternity Review in 2016, with conflicting demands on maternity leadership to implement change. All Maternity units across SES LMS have been part of the Maternal and Neonatal Safety Collaborative. There is a risk that organisations (and individuals) feel overwhelmed trying to progress these simultaneously.

Through this plan and its ongoing work, the LMS will act to distil and coordinate these initiatives into a single transformation programme, setting clear direction and agreeing actions for each provider. By signing off this plan, partner organisations are committing to improving the four core outcomes. The LMS will review and monitor progress against these, setting improvement trajectories and developing plans to achieve them.

9.3 Leading system-wide collaboration and transformation

National guidance has left space for local systems to innovate and design their own services. Co-production with women and families, as described in Section 9.1, plays a central role in this, but we need deeper collaboration across the health and social care system to deliver the vision fully. Through its diverse members, the LMS is uniquely placed to address the challenges in care that are difficult for organisations to address in isolation.

The LMS programme will enable this system wide collaboration and transformation in two distinct phases. The first phase will focus on breaking down structural and cultural barriers to facilitate cross-organisational partnerships, shared learning and service improvement. Building on this, the second phase will identify the opportunities and challenges that can only be unlocked through collaboration, supporting and supplementing the work of each partner to increase the overall quality, resilience and sustainability of the system of care.

9.3.1 Phase 1: Enabling system partnerships

The LMS will use Phase 1 to facilitate a new, collaborative way of working between organisations to unlock the full potential for improvement across the system. This will have three themes:

- Developing a culture of collaboration
- Enabling cross-organisational working
- Tackling common issues collectively

38 This includes the National Maternity Safety Strategy, Each Baby Counts and ATAIN programmes, MBRRACE maternal and perinatal mortality reports, Five Year Forward view for mental health as well as local GIRFT and CQC reports and planning guidance

9.3.1.1 Developing a culture of collaboration

Constructive system-wide collaboration is built on a foundation of strong relationships between individuals working across boundaries. The LMS provides an opportunity to bring together clinicians from across partner organisations to learn together as a single, multi-professional team, using leadership development and shared learning forums. These two initiatives will create a sense of belonging and identity with the LMS and eliminate current silos.

Learning and System Quality Improvement

The LMS will bring together obstetric, midwifery and public health clinical leads in a leadership development programme designed to give them (and their organisations) the capabilities to develop high performing teams which embed continuous quality improvement within their practice and culture. They will also work together on Quality Improvement opportunities at a system level, to accelerate progress and develop a "learning system" culture. This will build upon NHS Improvement's Maternal and Neonatal Safety Collaborative[39]. It will include a more overt focus on quality improvement as a system, tailored to the specific needs and challenges within Sussex and East Surrey.

We will supplement initial skills training with regular working sessions where leads will come together to collectively address the risks and issues facing their organisations and discuss new evidence and best practice as it emerges. By investing in the continued professional development of its leaders, the LMS will build engagement and enthusiasm within clinical teams and support organisations to embed continuous quality improvement.

Shared learning forums

LMS shared learning forums will disseminate and implement learnings across the system, including corrective actions from adverse events, new evidence and best practice and innovative new models of care. These forums will allow the LMS to engage the passion and drive of individuals within local teams, engaging all members in quality improvement and supporting the development of grassroots initiatives. Safety forums are being developed by the new Safety lead. The LMS team will be looking at the role of the HSIB investigations within these forums.

Multi-professional learning and discussion will help break down boundaries between individuals and organisations and instil an academic rigour to quality improvement projects. This will help service improvements deliver the greatest possible impact and value, whatever their scale.

9.3.1.2 Enabling cross-organisational working

To enable partnership working, there is an urgent need to break down structural barriers between organisations. These barriers persist from historic and isolated services and prevent effective collaboration by constraining information flow (including referrals and performance data), people (patients and staff) and funding. The LMS will put in place the infrastructure needed to support services to work together effectively, including:

- A single service specification co-designed with providers, commissioners and women. This will support the reduction of local variation by agreeing the minimum requirements of maternity providers, including specialist services, and key metrics to measure performance. Co-production will ensure services are centred around women and their families, deliverable by providers and are financially viable and sustainable.
- Standardised policies and protocols to optimise pathways, deliver timely access to specialist care and disseminate local innovation and best practice across the system. This will help increase efficiency across the system by reducing duplication and identifying opportunities to simplify unnecessarily complex policies and protocols across maternity services

39 Maternal and Neonatal Safety Collaborative is a training and coaching programme for nominated Trust Safety Leads which aims to build robust quality improvement skills within organisations. BSUH and SaSH are in Wave 1, with ESHT and WHST forming part of Wave 2 of implementation.

- An outcomes-based commissioning model that supports and encourages local service improvements and is backed up by shared data collection and performance review. This will develop and use standardised outcome measures that are more relevant to women and families. Simplifying existing commissioning arrangements will facilitate closer working between commissioners and providers. It will encourage greater transparency and data sharing that allows partners to honestly review improvement trajectories and targets and develop achievable action plans.
- Interoperable digital systems that streamline sharing of information and data between organisations and users. This will have a substantial impact across the system, increasing access to specialist care, reducing duplication and reducing the time burden of shared data collection and review.
- Strong links between Maternity Providers and with Community Healthy Child Programme Services to support the ongoing health and well-being of women and health sustain health improvements identified in the antenatal period. The creation of information sharing pathways would ensure all pregnant women are known to the Universal HCP services to enable these services to offer antenatal contact, assessment and support.

9.3.1.3 Tackling common issues collectively

The challenges facing partner organisations do not exist in isolation and often require a coordinated response to deliver sustainable change. Initially, we will focus on an understanding of workforce planning, provision of prevention services and access to perinatal mental health.

Workforce gaps

The partner organisations within the LMS will work to define current and future workforce challenges across all professions, and develop strategies and plans to collaborate on addressing them.

The partner organisations within the LMS will work collaboratively to model future workforce supply and demand, consider options for short and long-term solutions to tackle recruitment, retention, training and development challenges, and agree a common approach. Options to consider include:

- strategies to boost and secure the training pipeline
- strategies to maximise staff retention
- innovative ways of working
- creation of new roles
- expansion of responsibilities of current staff groups

An early priority will be to model the workforce needed to fully implement Better Births. This will include testing Continuity of Carer workforce models and ensuring access to sufficient sonographers to implement best practice monitoring approaches to reduce perinatal mortality.

The LMS will work collaboratively with the STP workforce workstream and Health Education England to access available support and ensure plans are aligned.

Prevention services

Improving access to prevention services, in line with the life course approach, a universal approach to attachment parenting and prevention agenda in the NHS Long Term Plan, will support the development of value-based, sustainable maternity services. The LMS will work with commissioners, providers and users to define needs and the services required to meet them, including targeted interventions to increase access by those in greatest need. We will set out a clear recommendation and case for investment to advocate and influence the commissioning of specialist prevention services.

Perinatal mental health

The LMS will work with the Perinatal Mental Health Network to develop services that are easily accessible and available to all women and to consider what services might be offered to fathers. This will include programmes for mild mental health needs such as antenatal relaxation programmes, facilitated self-help and IAPT counselling, through to emergency assessments and treatment for severe crises. Early identification of women at risk is vital and the LMS will support workforce training. This means identifying and addressing existing gaps and making the necessary changes in protocols to enable this, informed by ongoing service user engagement work. It also requires a joined up approach with implementation of continuity of care, identifying vulnerable women and offering them a dedicated midwife or team of midwives throughout their antenatal and postnatal period, and effective handover and partnership working with the Health Visiting teams and the Children and Families service.

9.3.2 Phase 2: Collaborating to deliver system-wide improvement

Progress by Early Adopters shows that deepening trust and alignment around a vision for the LMS reveals greater opportunity through collaborative system design and improvement. The LMS will lead standardisation and continuous improvement and develop enhanced service offers. We will achieve this through strategic pooled investment on system-wide priorities to improve outcomes, access, experience and efficiency. We will continue to support local systems to tailor local service delivery around the needs identified through service user engagement.

Based on delivering the four core outcomes of the LMS and the current challenges facing services, several early ideas for joint working have been identified, including:

- Joint delivery of community hubs, including integrated teams formed across the health and care system
- Consider a regional 24/7 pregnancy triage and advice line across Sussex and East Surrey
- Shared sub-specialist clinical (e.g. maternal and fetal medicine) and specialist midwifery teams (e.g. alcohol and substance abuse, young persons, etc) teams
- Single training curriculum and programme for maternity staff, allowing staff to work between organisations without duplicating training requirements
- Shared, specialist postnatal support programmes, including feeding support
- Working closely with fetal networks
- Strengthening partnership working to include data sharing of pregnancy cohort across maternity and HCPs to ensure equal access (e.g., to HCP antenatal contact, new birth visit, safeguarding)
- Working together to increase uptake of immunisation against influenza and pertussis

As the LMS progresses through the first phase it will strengthen relationships with the broader STP, including the developing STP Clinical Strategy. This will ensure LMS supports and is supported by approaches to place-based integrated transformation. The LMS will continue to engage with regulators and neighbouring LMSs, including Early Adopters, to determine the most valuable strategic developments to care delivery.

10 Delivering the vision

10.1 LMS transformation programme

The LMS has distilled the full range of service user opportunities into a defined programme of work, to be implemented over the next five years, as shown in Figure 21.

The work has been organised into nine workstreams, following guidance from NHS England and the National Maternity Transformation Programme. These can be divided into four cross-cutting enablers and five service improvement workstreams. These interlink and complement each other to deliver the four core outcomes.

Progress against these outcomes, implementation of service improvements and key issues will be reviewed in highlight reports within the LMS programme governance.

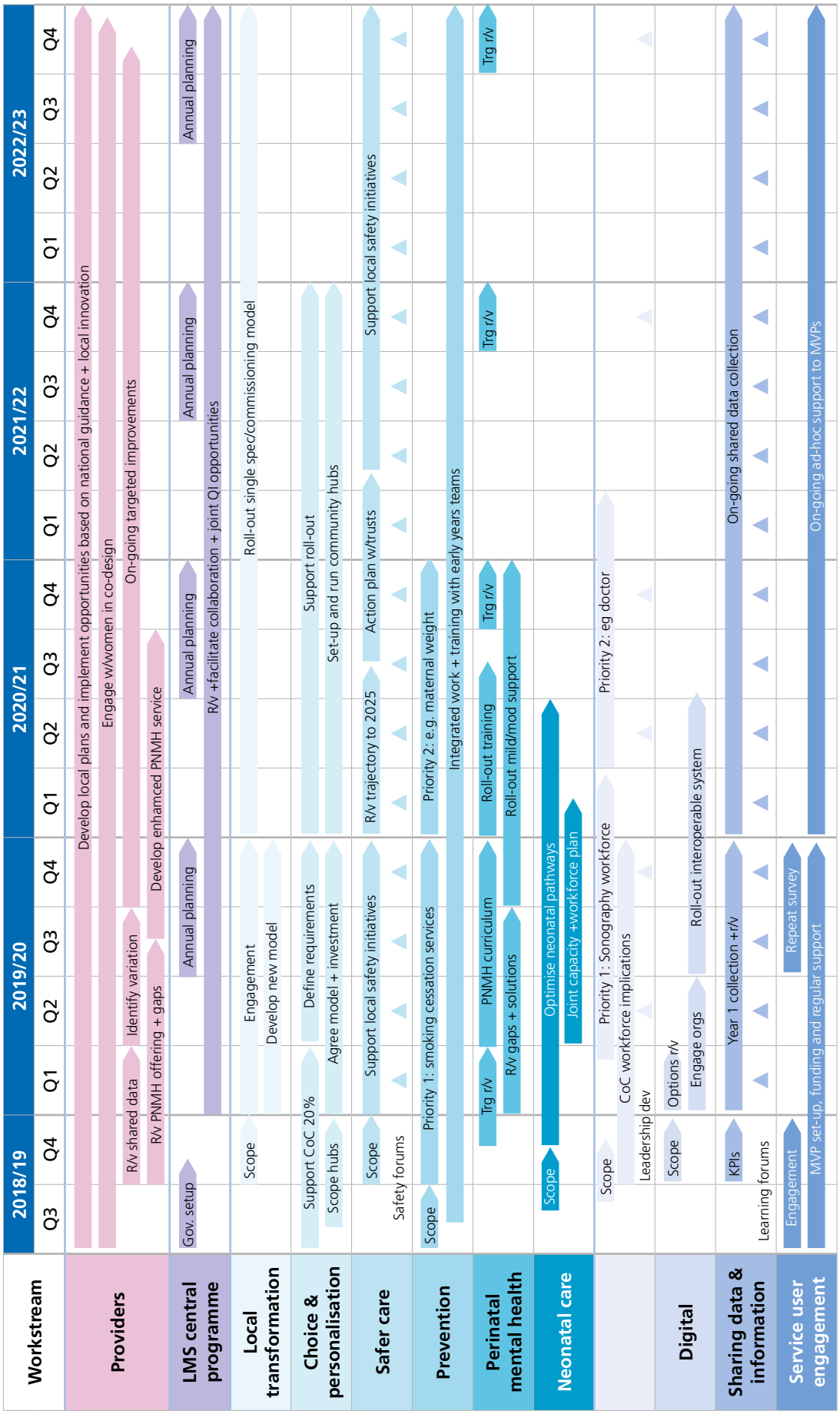

Figure 21: LMS Programme Plan on a page

10.1.1 Governance

Robust assurance and governance is essential to delivering the ambition of the LMS programme in a timely and efficient manner. The proposed LMS governance structure is shown in Figure 22 below. The LMS programme team and workstream leads will be responsible for coordinating and delivering the transformation plan, with oversight from the Senior Responsible Officer (SRO) and Executive Sponsor and input from the LMS Stakeholder Group.

An LMS-specific Programme Board is being formed, including senior decision makers and representation from partner organisations. This Board will monitor and review progress against the transformation plan and core outcomes through monthly highlight reports and help create the conditions for ongoing success.

To ensure close working with the STP, the LMS will provide assurance through the established STP governance structure and reporting cycle. The SRO will sit on the STP Operational Delivery Group and provide regular status and progress reports and updates to the Clinical and Professional Cabinet and STP Executive Group.

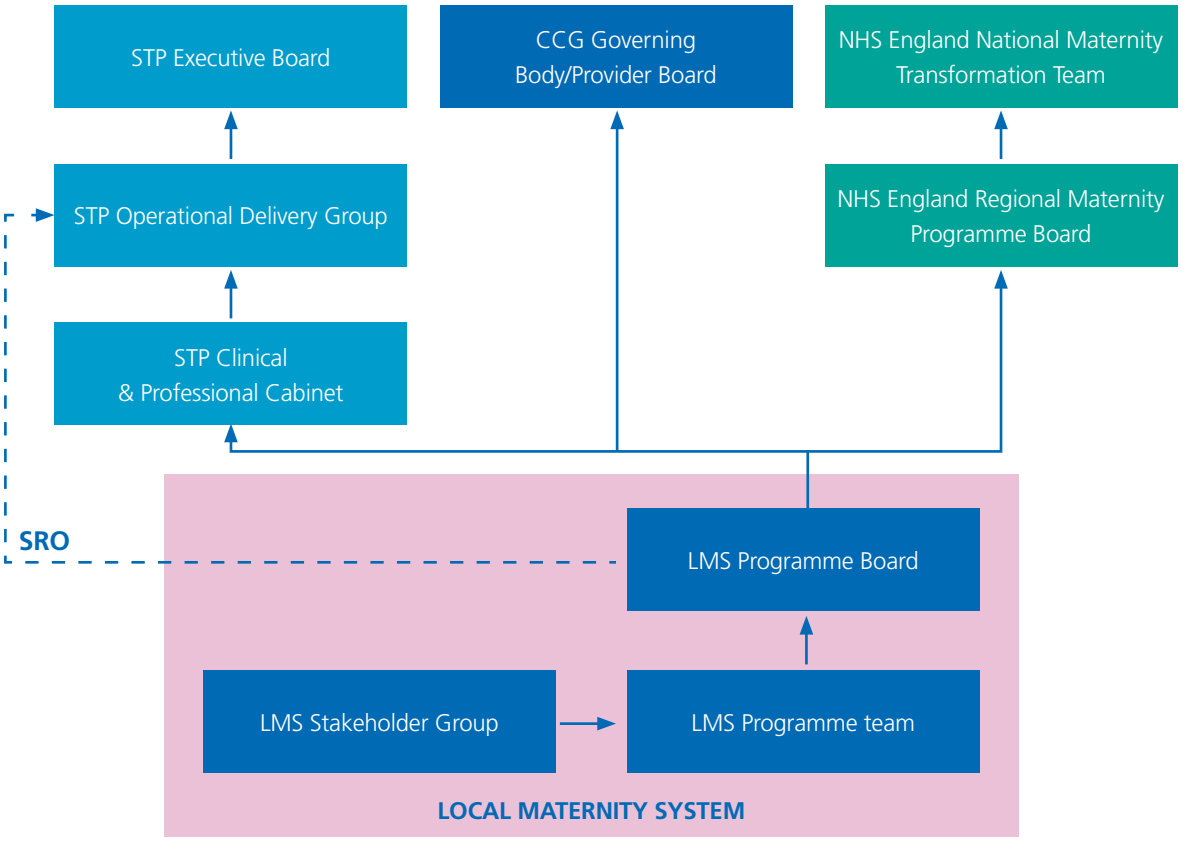

Figure 22: Proposed governance structure for the LMS

10.1.2 Financial planning

The LMS acknowledges the difficult financial situation of the STP and the need to develop solutions and interventions that are deliverable within this context.

Non-recurrent programme costs are funded centrally through the Maternity Transformation Programme, but service improvements and changes will where possible need to be resourced within current envelopes. Non recurrent central funding has been available for set-up and transitional costs, e.g. training to implement new ways of working.

Whilst investment in maternity services included in 2019/20 planning guidance and the NHS Long Term Plan are not known at the time of writing, the LMS assumes that flat, real-terms funding increases with investments above inflation will need to demonstrate significant value to women.

The LMS is committed to transitioning maternity services towards commissioning for outcomes and will use the LMS as a means to develop the approach collaboratively between providers and commissioners. We will develop a standard service specification to ensure consistent access to high quality care, taking note of local context to ensure services meet women's needs.

Subsequent workforce and financial modelling will be conducted as the full details of service improvements are defined. The LMS will work with NHS England and Early Adopters to determine the right way to realise the ambitions of Better Births locally. The LMS will also continue to link with the STP finance and workforce groups as this work is progressed, to ensure system-wide support for changes.

10.2 Working with the wider STP

10.2.1 System and organisational buy-in

Delivering and embedding the changes needed in maternity services requires engagement and support from system and organisational leadership. STP sign-off and support will raise the profile of maternity transformation, encouraging partner boards to prioritise and enable large-scale service improvements.

A key recommendation from the National Maternity Review and the Maternity Safety Strategy is maintaining a board level focus on maternity services by

- nominating a Maternity Services champion
- routine review of quality metrics
- investment of time and resources to implement necessary actions for quality improvement

This buy-in is essential to maintain the ambitious pace of change needed to deliver the Maternity Transformation Programme in line with national trajectories and targets.

We also need organisational focus so the LMS can meaningfully engage and collaborate with all necessary partners on significant system level changes: e.g. defining a new standardised service specification and commissioning model. These large-scale changes will lead to new ways of working and models of care - the explicit support of system and organisational leaders will be critical to ensuring their success.

10.2.2 Collaboration with other STP programmes of work

There is considerable overlap between the LMS and broader STP in the challenges faced and the work needed to address these: e.g. digital and workforce strategies and work to reduce unwarranted variation.

The LMS will work closely with the STP programme to ensure it is informed by the broader programme context. We will develop common solutions that dovetail across services and specialties.

In the context of digital and workforce strategies, the LMS will be led by the overall direction set by the STP, adapting and tailoring this to meet the specific needs of maternity services and their patient populations.

As described in Section Section 10.1.1 above, the LMS will formally report progress within the established STP governance structure and will use these forums to collaborate and manage interdependencies with other programmes and leads.

10.2.3 Strategic direction and oversight

The detailed design within certain aspects of the LMS will require more rigorous and thorough exploration and analysis. This detailed work will lead to clear choices on the future direction of the programme, with potential implications for the improvements achieved and investment required. The LMS has identified three initial priority areas where such work will be required:

1. Delivery of case-loading midwifery teams (under Continuity of Carer recommendations) to meet national trajectories and the associated workforce and investment requirements, informed by the evaluation of the initial roll-out and results from Early Adopters.
2. Continued funding of the Perinatal Mental Health network, potentially from local sources after the expiry of central funding programmes
3. Increased focus on prevention services, the impact of this on income and expenditure for relevant organisations and system level benefits.

For each of these areas, the LMS will define and deliver options appraisals under the guidance of the STP Executive Group. We will include engagement, testing and input from all relevant organisational and clinical leads and service user representatives. The end result will be a clear analysis and conclusion of the findings,, recommendation and, where relevant, a business case, endorsed by the STP Executive Group followed by sign-off by local governing bodies and provider boards. This work is currently being undertaken as part of the LMS programme and the STP can expect further detail, including progress updates and requests for input as this work progresses. It is worth noting that the approval process across the STP footprint is complex and requires lead time over 3-6 months.

The LMS is excited by the opportunity this plan represents. We are committed to transforming care for women and babies by strengthening collaboration between partners. Coming together as a maternity system will leverage the individual strengths of partner organisations, enabling shared learning, cross-boundary and organisational working. The ultimate goal is a system-wide transformation that will benefit women, staff and the entire system.

Appendix 1
Core Partner Organisations of Sussex and East Surrey LMS

Brighton & Hove CCG

Coastal West Sussex CCG

Crawley CCG

East Surrey CCG

Eastbourne Hailsham & Seaford CCG

Hastings & Rother CCG

High Weald Lewes Havens CCG

Horsham & Mid Sussex CCG

Brighton & Sussex University Hospitals NHS Trust

Surrey & Sussex Healthcare NHS Trust

Western Sussex Hospitals NHS Foundation Trust

East Sussex Healthcare NHS Trust

Sussex Community NHS Foundation Trust

Maternity Voices Partnerships Representatives –

East Sussex MVP
Mid Sussex MVP
Brighton & Hove MVP
Western Sussex MVP
Surrey & Sussex Hospital MVP

South East Coast Ambulance Service

NHS England (South East Clinical Network)

South East Neonatal Operational Delivery Network

Local Authority Representatives

Primary Care Representatives

Public Health England (South East)

Sussex Partnership Foundation Trust

Sussex Perinatal Mental Health Network Representative

Sussex & East Surrey
Sustainability & Transformation Partnership

Supporting **better births** in **Sussex and East Surrey**

January 2019