North Cumbria
Clinical Commissioning Group

NHS North Cumbria CCG Governing Body	Agenda Item
6 December 2017	10

Better Birth Plans

Purpose of the Report								
To update the Governing Body on the development of the 'Better Births' plan.								
Outcome Required:	Approve		Ratify		For Discussion	**X**	For Information	

Assurance Framework Reference:

1, Better Health – There is a need to ensure that our maternity services can respond to the recommendations from the national maternity review
2, Better Care – Commission services that ensure the delivery of high quality and safe care for patients
3, Sustainability – Commission services that ensure the delivery of high quality and safe care for patients in a manner that is sustainable for the whole health economy

Recommendation(s):

The Governing Body is asked to discuss and support the direction of travel

Executive Summary:

Key Issues:

- Plan has been developed with the Maternity team, the Cumbria and North East maternity network, NCCCG, Public health, CPFT mental health team and local women via the Maternity Voices Partnership (MVP)
- It is part of the national 'Better Births' programme and is about understanding and developing the whole maternity pathway (ante natal care, the birth and post natal care
- The first draft plan (attached) was submitted nationally on 31/10/17 following sign off by the NCCCG Executive and the STP Senior Leadership Board. All plans at this stage are known to be incomplete
- Since submission it has been through assurance and check and challenge processes with the North of England maternity board – feedback is expected in mid December. The next

version of the plan is due for submission on 31/01/18 and will include more detailed trajectories linked to our ambition and more detail on proposed continuity of carer pilot projects

- A strength for us is that this ties together the decisions from the consultation, the Better Births agenda , the STP programme all in one place
- There is much work to do , with service users, staff and key partners to further develop and implement the plan over the coming years
- We now have funding for project management and senior midwifery time for development which was much needed

Key Risks:

- Continuity of carer – delivery of national expectations in terms of availability of workforce, cost and geography
- Complexity of delivery of Community maternity hubs using existing resources across multiple partnerships
- All issues associated with sustainability of maternity and associated services

Implications/Actions for Public and Patient Engagement:

- Plan produced with Maternity voices partnership
- Community hubs will be co-produced

Financial Impact on the CCG:

- In line with PCBC – there may be additional cost arising from community hubs and continuity of carer

Strategic Objective(s) supported by this paper:	**Please select (X)**
Support quality improvement within existing services including General Practice	**X**
Commission a range of health services appropriate to Cumbria's Needs	**X**
Develop our system leadership role and our effectiveness as a partner	**X**
Improve our organisation and support our staff to excel	

Impact assessment: (Including Health, Equality, Diversity and Human Rights)	Impact assessments undertaken as part of consultation process. This will be added to.

Conflicts of Interest Describe any possible Conflicts of interest associated with this paper, and how they will be managed	No conflicts of interest have been identified.

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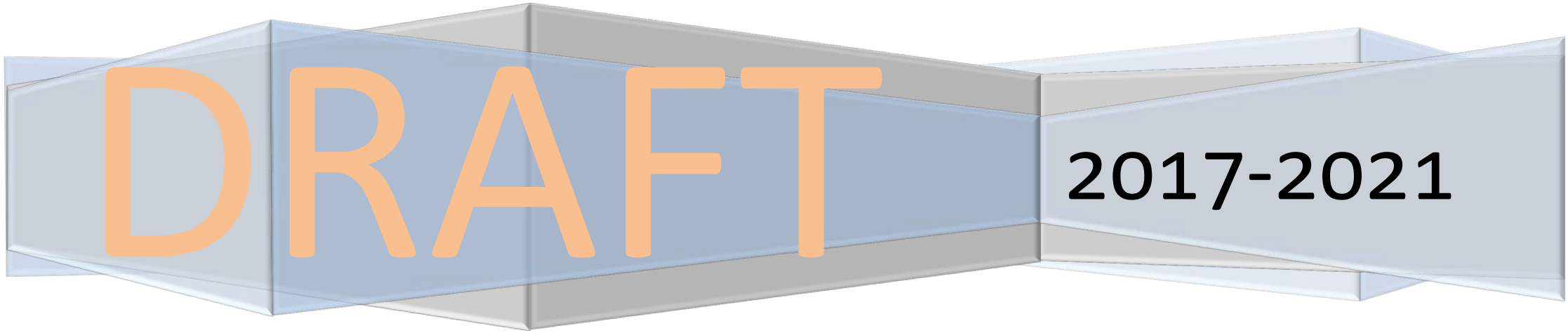
Date Report Written	Up to 31 October 2017

West North and East Cumbria Better Births Plan (Local Maternity System)

Developed by the Local Maternity System Board including the Maternity Voices Partnership (MVP)



Contents

1.0 Introduction and context

Maternity services have been reviewed in Cumbria over a number of years, with work taking place to ensure that services are safe and sustainable. The focus for many has been on the place of birth, however the quality and experience of the whole maternity journey from pre-conception to delivery is essential for the delivery of better health outcomes for mother and baby.

This plan is written against a background of the 'Healthcare for The Future' public consultation which ran from 26 September 2016 to 19 December 2016 and the publication of 'Better Births' which is a national blue print for the end to end maternity pathway.

Due to our rurality and isolated geography there are concerns about the sustainability of maternity and interdependent services including obstetrics, paediatrics and anaesthetics.

The intent of this document is not to rehearse the detail of the local consultation but to concentrate on improving the maternity pathway with women for women in line with Better Births. The consultation decisions can be found in appendix one.

The Better Births' recommendations highlight seven key priorities to drive improvement and ensure women and babies receive excellent care wherever they live. Different elements of the recommendations are to be delivered at national, regional and local level.

Achieving this vision requires actions from commissioners and providers working together as well as a range of other local & regional stakeholders, supported by national bodies. The golden thread of improving safety runs through the work and will achieve the Secretary of State's ambition to reduce the number of still births, neonatal and maternal deaths, and brain injuries by 50% by the Year 2030.

Our Sustainability and Transformation Partnership (STP) – the West, North and East Cumbria Health and Care Partnership - and therefore Local Maternity System, is very small (approx 3000 births) and therefore the relationship with the Cumbria and North East Maternity Network is of critical importance to us. The relationship will continue to grow.

Locally we have a strong relationship with the Maternity Voices Partnership and also have an infrastructure to support co-production with our community following the consultation – this gives us a firm foundation on which to build the LMS work.

2.0 Population – facts and figures

The total population of WNE Cumbria is approx. 327, 000 (c.65% of the wider Cumbria population) and geographically, is defined as the districts of:

- Allerdale - 96,471 residents.
- Copeland - 69,832 residents
- Carlisle - 108,022 residents.
- Eden - 52,630 residents.

WNE Cumbria is one of the most rural counties in England, averaging a population density of 74 people per sq.km (Eden having lowest at 25 people per sq. km). Carlisle has a population of around 100,000 people

The other major conurbations are the adjacent towns of Workington and Whitehaven, both with populations of roughly 25,000 people, and are located on Cumbria's west coast. Despite their population size these towns are geographically isolated (removed from essential services and with poor transport links) being 30 and 39 miles respectively from Cumbria's largest urban centre Carlisle and 100 miles from Newcastle (the nearest Metropolitan City) and its specialised tertiary NHS services.

Other population data insights taken from Cumbria County Council's Joint Strategic Needs Assessment (JSNA) include:

- Cumbria is England's second largest county and is much less densely populated than the national average;
- Allerdale and Eden have the greatest proportions of residents living in rural areas (72% and 71% respectively); while Carlisle has the smallest proportion (27%);
- Households without access to a car – Copeland 23.4 per cent / Allerdale 20.8 per cent / Eden – 13.9 per cent / Carlisle 24.7 per cent ;
- West Cumberland Hospital serves the population south of Whitehaven including those up Wasdale / Eskdale / Ennerdale valleys with small country roads / poor broadband / poor mobile phone reception

- Cumbria has a much smaller proportion of residents from Black, Asian and Minority Ethnic (BAME) groups than the national average (3.5% vs 19.5%) (Carlisle had the greatest BME population at 5%);

- Cumbria's proportion of residents reporting that their day-to-day activities are limited by a health problem or disability is higher than the national average (20.3% vs. 17.9%);

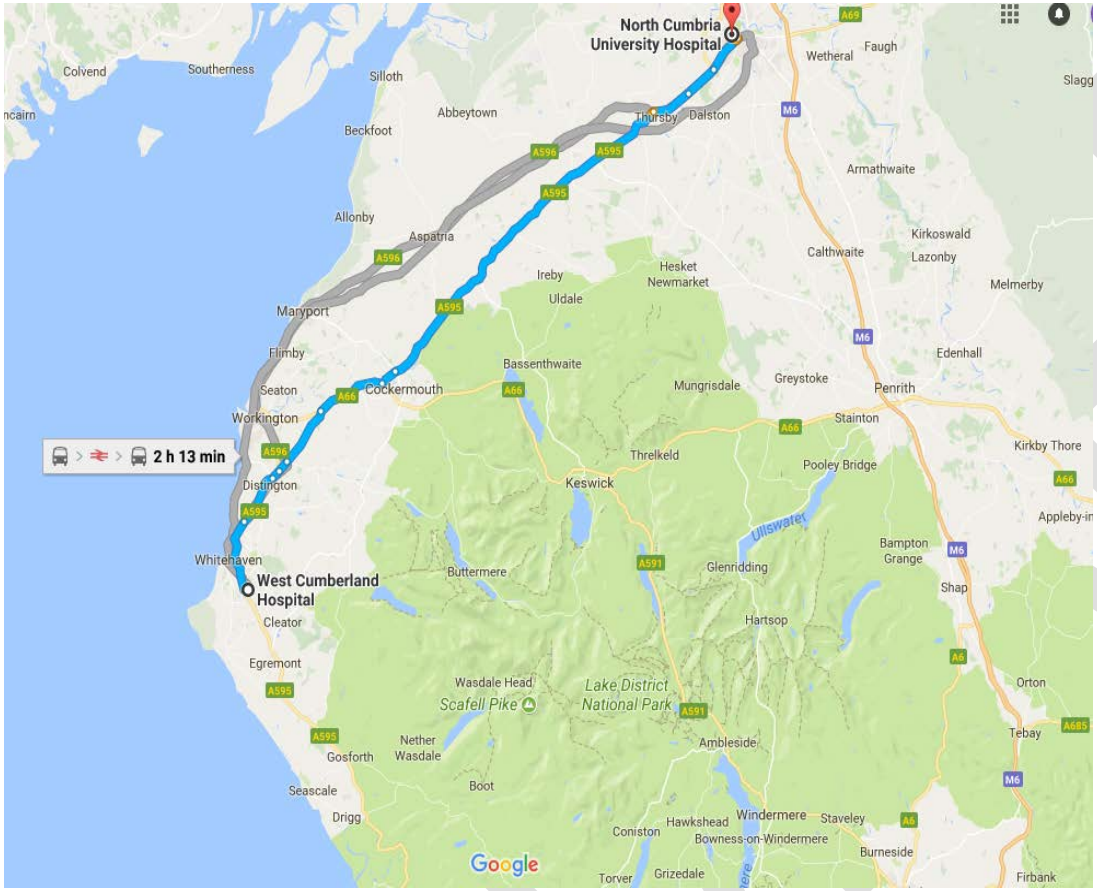
- Projections of recent demographic trends suggest that by 2017 Cumbria's population will decrease by 1,400 persons (-0.3%), with numbers of 0-14 year olds decreasing by 300 persons (-0.4%) and 15-64 year olds decreasing by 13,500 persons (-4.3%), while numbers of residents aged 65+ increase by 12,300 persons (+11.4%);

3.0 Maternity services available and birth numbers – 2016/2017

- Cumberland Infirmary Carlisle – 1650 births pa – (CLU with AMLU being developed)
- West Cumberland Hospital, Whitehaven - 1257 births pa (CLU with AMLU being developed)
- Penrith Birth Centre - 31 births
- Home births – 39
- A range of antenatal and postnatal care is available across the area

3.1 The challenges of our geography - The distance between CIC and WCH is 39 miles with an average travel time of 1 hour 15 minutes. The road infrastructure is poor, slow and often disrupted. (A595 and A596 – slow moving traffic / roadworks / accidents / severe weather regularly impact travel time).
The Trust also provides maternity services to the Millom area which is part of the adjacent Lancashire and South Cumbria LMS.

North Cumbria Map



4.0 How have we devised our plan?

Our plan is defined by four key components:-

- What women have told (and continue to tell) us they want
- The health needs analysis in West, North and East Cumbria
- The gap analysis against the Better Births recommendations from a service and user perspective
- An emphasis on co-production with women – we have a co- production infrastructure in place.

We have taken all the above to come up with our aspirations and plan. In addition we have linked in to the planning processes with our neighbouring LMS via the Cumbria and North East Maternity Network.

5.0 What women tell us they want

Locally, in 2015, work was undertaken by Healthwatch and the Maternity Services Liaison Committees (MSLCs), to gauge the views of women and families across the full maternity pathway. This has been supplemented by an analysis of other sources of feedback including the MVP feedback mechanisms.

Feedback on all subjects includes very positive comments and much praise for the services and midwives in particular from the majority of women. But others do believe the services could improve and in particular:-

- **Locally accessible services** and real accessible choice of birth environment. The importance of local services was stressed with more than half saying that they thought less than 20 minutes travelling for antenatal care was reasonable and around one third saying 20 to 40 minutes. For labour 60 % said less than 20 mins with 37% saying within 20 to 40 minutes.
- **Antenatal care** – Most women are generally satisfied with antenatal care, but with some concerns re distance, parking and facilities
- **Birth plans** - Most women have birth plans but some feel they are not always followed, and some do not feel listened to and mention pain relief as a key issue. Women value support to make informed choices

- **Postnatal care** – In acute setting this is seen by some as overstretched and there is a need for more contact with staff in the hours after the birth. There is strong opinion to improve consistency and quality of postnatal support for breastfeeding. 6 week checks need to also focus on the mum as well as the baby.
- **Peri-natal mental health** – to be added after specific survey work (being undertaken November 2017)
- **Continuity of care and carer** throughout pregnancy, birth and the postnatal period leading to inconsistent care and support. High majority of women feel this is of greatest importance.
- **Facilities** – need improvement and some felt could be cleaner. Facilities for Dads need improvement.
- **Information and communication** – can be inconsistent and need to be improved including information for women to make informed decisions and choices.

The above results will continue to inform the work moving forward. It should be noted that satisfaction with the local services is high and the service wants to build on the strengths that local women already value.

Key areas of improvement focus chosen by the MVP – 2017

West Cumbria

- Involvement of fathers – keeping family together.
- SCBU support for mother/Breast feeding
- Facilities improvement
- Breast Feeding/ Infant feeding support

North and East Cumbria

- Home Births
- Involvement of fathers – keeping family together.
- Breastfeeding/ Infant Feeding support
- Improved specialist outreach perinatal mental health services

6.0 Population health (maternity related) in West, North and East Cumbria – detail at appendix two

Infant Mortality (crude rate of deaths in infants aged under 1 year per 1,000 live births 2013-2015)
The infant mortality rate in districts across WNE Cumbria (2013-15) ranges between 0.8 (Eden) and 3.7 (Allerdale). No district has a significantly different rate from either the Cumbria or England average.

Low Birth Weight
During 2015, the percentage of children born with a low birth weight across the districts across WNE Cumbria (Allerdale, Carlisle, Copeland and Eden) ranged between 2.1% in Allerdale to 4.3% in Copeland (see table below). The percentage of babies born with a low birth weight in Copeland (4.3%) is significantly higher than both the Cumbria (3.0%) and national (2.8%) average. When you compare the percentage in Copeland to other comparable districts across the country, the value is still an outlier due to being significantly higher than the national average.

Smoking status at time of delivery (% of women who smoke at time of delivery)
During 2015/16, 12.3% of women in Cumbria were recorded as smoking at time of delivery (data not available at district level). This is significantly higher than the national average of 10.6% (however it should be noted that the national data has quality issues, due to the high number of women whose smoking status is not recorded at time of delivery across all Trusts)

Breastfeeding
Breastfeeding rates are measured at initiation (when a mother gives birth) and again at 6-8 weeks. All districts except Eden have rates that are significantly lower than the England average

Under 18s conception rate (crude rate per 1,000)
Across the districts of WNE Cumbria, under 18 conception rates range from 12.8 (Eden) to 26.5 (Carlisle). No areas have a rate significantly different to either the Cumbria, or the England average - Source: PHOF, 2015. (2.04).

Vaccination delivery during Pregnancy
Women are advised to be vaccinated against flu and Pertussis (Whooping Cough) during pregnancy. During 2016/17, the target set by NHS England for Flu vaccine coverage during pregnancy was 55%. Cumbria achieved 49.7% coverage during this time period, therefore falling short

of the set target. There is evidence to suggest that vaccine uptake rates during pregnancy are improved when community midwives administer the vaccine (rather than pregnant women having to book separate appointments with for example, practice nurses). Currently, midwives based with NCUHT do not administer vaccines to pregnant women.

Alcohol Consumption

In May 2017, Public Health England released its latest local alcohol profiles for England (LAPE). Whilst there is no data specific to alcohol use before, during or after pregnancy, the data does indicate that the rate of hospital admissions due to alcohol related conditions is above the national average in Copeland and Carlisle. The rates of alcohol specific mortality and benefit claims (due to alcoholism) are also significantly above the national average for the Allerdale district. The reported rates in Eden are significantly better than the national average.

Overweight and Obesity

Allerdale, Carlisle and Copeland all have rates of excess weight significantly higher than the national average. Allerdale is now ranked as the district with the highest percentage of adults with excess weight in the whole England.

6.1 Health Needs in WNE Cumbria – our ambition

Must Do	Initiative	Goal	Outcome/Ambition
Breastfeeding	Achievement of UNICEF Baby Friendly Initiative (BFI) Level 3 – Maternity and Community (Early Help) Settings	100% settings to have achieved BFI Level 3 by March 2021	• Increase breastfeeding initiation % to be in line with national average (currently 74.3%) • Continuation of Breastfeeding – improve recording so baseline % can be established by end of 2018/19
Maternal Healthy Weight	Agree pathways between maternity services and Tier 2 weight management programme.	Tier 2 pathway agreed – Dec 2017	• Reduce adult overweight & obesity prevalence to the following targets by 2021: • Copeland and Allerdale (achieve reduction to meet county average of 67.3%) • Carlisle and Eden (achieve reduction to meet national average of 64.6%)

Smoking in Pregnancy	Through policy and training, ensure a consistent approach across all maternity services (CO monitoring, brief advice, access to NRT and automatic referral to Stop Smoking service)	By 2021, 100% of: • Women with CO levels recorded at booking • Midwives trained in offering brief advice • Women identified as smoking being referred to stop smoking services	• New national Tobacco Control Plan target - reduce smoking during pregnancy rates to 6% or less • Rate in North Cumbria currently 12.3% at time of birth.
Alcohol consumption during pregnancy	Maximise use of an alcohol identification and brief advice (IBA) approach in maternity settings	80% of midwives completing IBA training by end of June 2018	• 100% of women receiving alcohol IBA at booking appointment by 2021
Immunisations: Flu and Pertussis	Review role of community midwives in administering vaccines during pregnancy	100% of midwives able to administer flu and pertussis vaccine to pregnant women by 2021	• Improved uptake rates: • Flu – minimum of 55% (currently 49.7%)

7.0 Gap analysis work and our ambition of how service will look in the future

Better Births – themes	Current service provision	User perspective via MVP

Personalised care	NCUHT uses the perinatal institute handheld records which includes personalised care plans but they are not always filled in by all	Are the care plans listened to? Need to take into account involvement of father or birth supporter at all stages. Note that, some don't want a plan in case it jinxes the birth.
Unbiased information	There is locally produced and nationally available information	Local information important for women to make choices (local transfer rates, local outcomes by site, BBA's home births cancelled etc), and information that relates to our geographic context
Choice of provider	There is no access to private providers in North Cumbria and no contracts in place	Only small numbers have any real choice of provider due to distance and no personal budget availability as Penrith Birth centre is outside of 'reasonable travel' time in labour for large part of population.
Support during birth and place of birth	Choice in place of home birth, Penrith birth centre, midwifery led care beds and CLU	Choice limited due to distance/ travel times. Some women don't get their planned home birth due to staffing issues. Midwifery-led accommodation not ideal, shares obstetric corridor and staffing, no dedicated entrance. Choice could reduce further if CLU's merge
Continuity of carer – small teams of midwives known to the woman	Mixed picture for antenatal and postnatal care – some areas are good. This does not extend to include the birth itself	Very important to women. Mixed picture with no model covering antenatal, birth and post-natal care. Some good obstetric continuity of care reported.

An identified obstetrician linking into each local team	Currently accessible on a specialist basis rather than geographical area	Currently accessible on a specialist basis rather than geographical area
Community hubs	Wide access to services – some areas lend themselves well to small known teams and hub concept.	Ease of access important. Not sure how hubs will work in large area with dispersed population. Some areas have a natural hub location others don't.
Joined up care – easy referral	Risk assessment continuous followed by referral if appropriate	Some women with complex pregnancies report not enough contact with named midwife
Collecting data on quality and outcomes	Captured on the maternity dashboards and via user feedback which is used to develop services	No current way in which all sources of feedback across trust and MVP are brought together
Perinatal mental health services	Some gaps and some good practice in place across end to end pathway. New mother and baby beds being commissioned in Chorley. Beds in Morpeth will also continue to be used	There are gaps and women have to travel approx 100 miles for mother and baby unit care
Post-natal care	Minimum of 3 post-natal visits plus additional input if required. Contact numbers available in and out of hours.	Some women feel abandoned after the birth after lots of contact previously. Lack of support with breastfeeding and lack of support after SCBU discharge.

Smooth transition between midwife, obstetric and neo natal care	Transition takes place and has not been flagged up by women as an issue to NCUHT as part of user feedback.	Concern re interface with SCBU including access to post-natal checks. Variable quality of six week checks. Concern re diminishing breast feeding peer support groups. Fewer health visitors means less input too

8.0 Our Vision

Our vision is derived from the 'Better Births 'vision and resonates strongly with local women.

"*Our vision is to commission and provide maternity services which are **safer**, **more personalised, kinder, professional** and more **family friendly**; where every woman has **access to information** to enable her to **make decisions about her care**; and where she and her baby can access support that is centred around their **individual needs** and circumstances.*

"All staff need to be supported to deliver care which is women centred, working in high performing teams, in an organisation which is well led and in a culture which promotes innovation, continuous learning, and breaks down organisational and professional boundaries."

8.1 Objectives for 2017- 2021

- To have safe and sustainable services
- To continuously improve to provide the best services for women and their families
- To work with the maternity voices in partnership to develop services which are truly based around the needs of women
- To have effective partnerships with local staff, the North East Local Maternity Systems, Public Health Commissioners and NHS England Specialised Commissioning to strengthen local provision

To implement the Better Births recommendations in North Cumbria with emphasis on:

- The development of small place based midwifery teams to enhance continuity of carer within a network of maternity hubs
- Increasing the choice of birth environment by introducing Alongside Midwifery Led Units (AMLUs)
- Fully developing the use of birth plans as a means to support women to have the birth experience they would choose
- Fully develop the one team / two site/ multi -disciplinary approach for maternity
- Co – production / co design of all elements of service development and provision with women and partners and the community
- Full development and implementation of the safety agenda

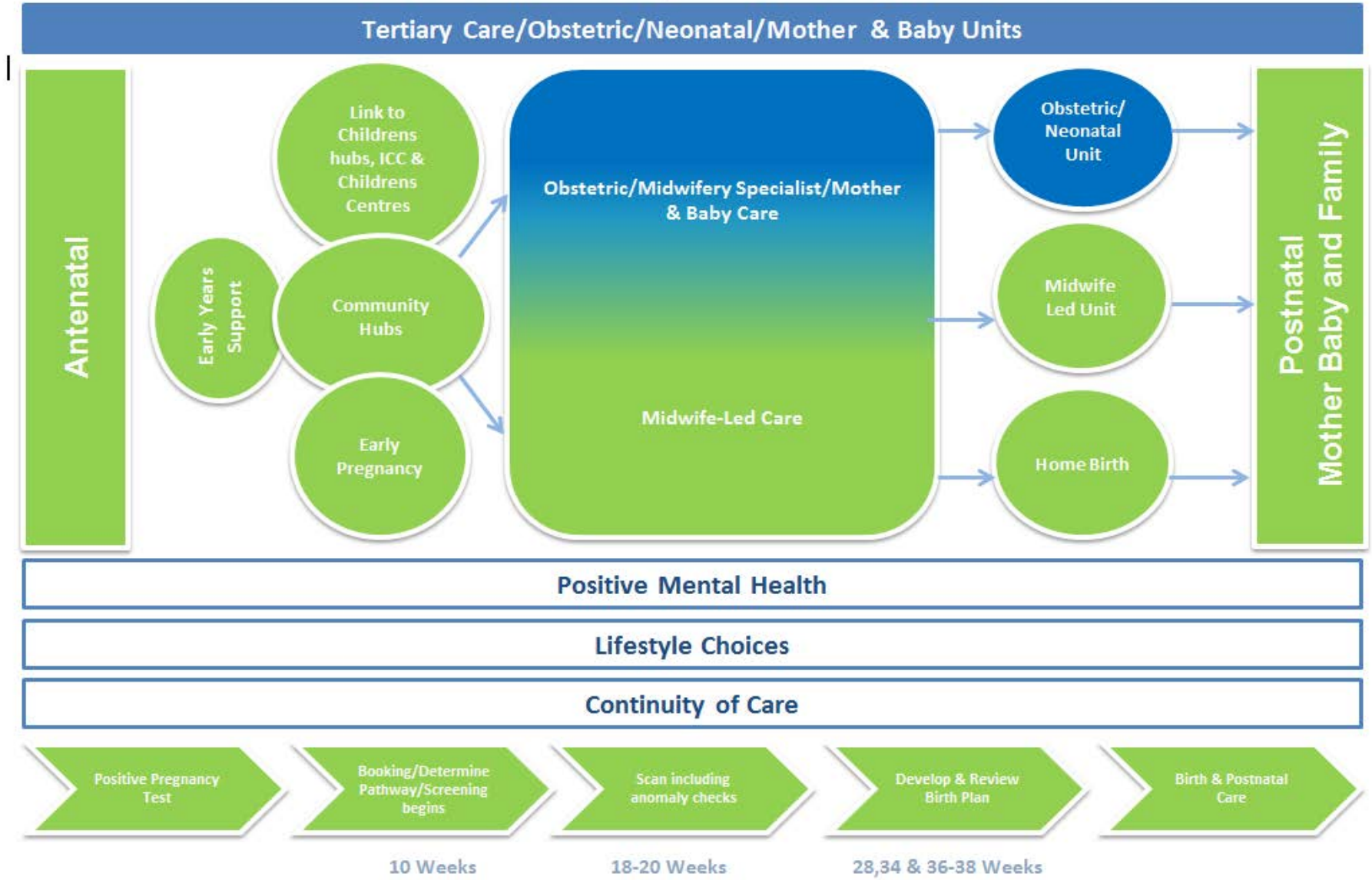
8.2 Our Goals – 2017-2021

- To contribute to the national target for saving babies lives – local rates will be monitored and lessons learnt.
- To have Identifiable maternity hubs operating by 2020 in line with the needs of the population and our geography
- To have 2 x AMLUs fully operational by 31/03/18 increasing choice for local women.
- To increase the number of women, year on year,who remain on the midwifery led pathway (including AMLUs) by 2020.
- To increase the number of women who experience continuity of carer year on year.

8.3 Our proposed model of care

The diagrams below show our proposed model of care incorporating the concept of community maternity hubs.

WNE Cumbria Proposed Model of Care



Community/Maternity Hub – Initial Feedback – Users of the Service & Professionals

Estate must be fit for purpose

Ideally Maternity hub with community centre/childrens centre or ICC

Some hubs could be virtual

9.0 Our aspirations

BB Objective 1 - Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.	
Every woman should develop a personalised care plan, with their midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses and after the birth.	**Care plans will be truly personalised as well as being based on the offer of safe, effective and clinically appropriate (in relation to risk factors) care and will be centred on women's needs and decisions** • All women will have the opportunity to and will be encouraged to complete a birth plan – (we will take note that some – expected to be small numbers - do not want to write it down in this way). Individualised care planning will be developed – empowering women to make their choices, supported by the midwife. Specific work will take place with more vulnerable women - to make sure those with the greatest need and vulnerability can benefit most. This will include those with mental health, learning disabilities, drugs and alcohol problems, domestic abuse victims and young parents. • A Mothers need for support from her partner/birth supporter, and the partners need for involvement & support will be taken account of • We will support women and families to enter pregnancy and childbirth in the best of health and wellbeing. Through policy and training, we will have a consistent approach across all maternity services to reduce smoking in pregnancy, alcohol consumption and to maintain a healthy weight.- this is an essential element of the care plan. • We plan to review the use of notes in line with our neighbouring LMS areas within the maternity network. Note - There will be times when a woman's birth plan cannot be adhered to due to change in circumstances

Unbiased information should be available to all women to help them make their decisions and develop their care plan drawing on the latest evidence, and assessment of their individual needs, and what services are available locally. This should be through their digital maternity tool.	**We will have locally-produced, unbiased information (written, spoken and in different languages), describing and increasing the understanding of services that are available – which will include an offer of birth options.** • Early work is taking place on revision of information on making choices and developing a birth plan
Women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget.	**Women's choices will be met – i.e. Homebirth etc and that there will be capacity in terms of staffing and facilities to deliver those choices** • Choice of provider is limited in North Cumbria due to geography; there is marginally more choice for the minority who live on the boundaries of the area. • We will look at NHS personal maternity care budgets on line with national expectations
Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit after full discussion of the benefits and risks associated with each option.	**We will offer a range of choices of birth environment to local women.** • We will increase the numbers of women staying on the midwifery led pathway year on year including home births • We have defined and implemented the model of midwifery led care • We will have alongside midwifery led units (AMLU) in place at West Cumberland Hospital and Cumberland infirmary, Carlisle • The AMLU environments have been designed with women and include drop down beds for Dads and birth partners. • Home birth, AMLU (CIC and WCH), Birthing Unit (Penrith) and CLU (WCH and CIC) will be offered. • We will increase infant feeding support via the achievement of UNICEF Baby Friendly Initiative (BFI) Level 3 – Maternity and Community (Early Help) Settings by March 2021

	NB: As at 31/10/17 the final site configuration is dependent on the outcome of the Secretary of State referral / success of co-production and sustainability of Option 1 following the decision making following consultation - this would not affect the number of choices but could affect geographical access. If access is reduced more work will be done on how women and families will access remote inpatient obstetric care / SCBU etc. The views of women on 'real choice' as expressed in the consultation and MVP feedback should be noted. Any change in service configuration is seen to reduce real choice.
BB Objective 2 – Continuity of Carer, to ensure safer care based on a relationship of mutual trust and respect in line with the woman's decisions	
Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.	**We will build on current good practice in ante natal and post-natal continuity of care and look at national pilots/ guidance and work with CNE maternity network to find workable solutions to improve continuity of carer including intra partum care.** • Each woman will have a named midwife - and will know the wider team. • Continuity of carer can be achieved for antenatal and post-natal care by working in small teams with named lead midwives – In some of our areas it is possible to work in small teams and provide good continuity now and we will build on this. • Continuity of carer will be targeted on those who will benefit most in the first place • Covering the actual birth with the same midwife or small team is much more challenging particularly with a wide geographical area to cover – we will note of the findings of national pilots areas and national guidance, work with the CNE network and local midwives to pilot ways of working to achieve improvements in continuity of care along the full pathway in line with the wishes of local women. We will work with the network HOMs groups (surveying the workforce to find solutions and get their views) and places further afield that have similar geography to ours e.g. Powys to find innovative solutions • We will use the results of process mapping (with women) of the service to get the best results for women – enhancing continuity of carer, looking at new roles and cutting out unnecessary steps

Each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate.	**There will be named obstetricians for each team as well as having speciality based leads.** • We will pilot in two areas to make sure we get this right and roll out.
Community hubs should enable them to access care in the community from their midwife and from a range of others services, particularly for antenatal and postnatal care. The woman's midwife should liaise closely with obstetric, neonatal and other services ensuring that they get the care they need and that it is joined up with the care they are receiving in the community.	**We will work with partners to develop community hubs in line with the views of women and midwives and our geography - We see the development of community maternity hubs as particularly important in our community.** • We are co-producing our local solution with women and will identify the best option for a geographically dispersed area in partnership with local Integrated Care Communities (ICCs) and Cumbria County Council children's services and public health teams. • The development of the concept of community hubs to provide a local centre where maternity services are provided alongside other family-orientated health and social services is linked to this work. This will enable women to have bespoke continuity of care packages with a group of named midwives in a small midwifery team; these midwifery teams will be working alongside a multi-disciplinary team and named obstetrician. • A Workshop on the development of community hubs was held with Cumbria County Council and the 3rd sector late 2016. The strong message from this workshop was that this service should not be standalone – it should be part of other service delivery i.e. children's centres or GP premises/ Integrated care communities. Another workshop will take place in 2017/18. • The MVP has started to gather the views of women and the solution will be co-produced with them, local midwives and other professionals. • This will work alongside and in partnership with the co-production work which will help shape the service.
BB Objective 3 Safer care, with professionals working together across boundaries to ensure rapid referral and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.	

Provider organisation boards should designate a board member as the board level lead for maternity services. The Board should routinely monitor information about quality, including safety and take necessary action to improve quality.	**The board will ensure that all aspects of safer care are in place** • The Trust board is fully committed to the continuous improvement of safety and quality and the Executive Director of Nursing is the board level lead for NCUHT. • The maternity dashboard and other safety reports are reviewed in the Maternity Joint Risk Group (weekly).This group feeds into the Maternity Governance meeting (monthly), the Women's & children and Radiology Safety & Quality meeting (monthly), The Trust Safety & quality Committee and into the Trust Board. • The trust will continue to review and refine its governance systems to ensure continuous improvement • The emphasis on safety includes access to clinical and safeguarding supervision
Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi- professional training.	**The Trust is committed to continuous improvement – and the creation of a flexible learning organisation that continually grows and develops its staff in order to respond to the demands and challenges of services. A quality improvement plan will be in place which promotes a culture of learning and continuous improvement** • Plans are in place to fully support the aims of 'Saving babies lives' which calls for a reduction in perinatal, maternal and still births by 2020. The National Ambition is to halve the rate of still births by 2030 with a 20% reduction by 2020. (This will be monitored at local level and any cases learnt from). The trust is part of the care bundle initiative and evaluation study for reducing still births and is implementing 4 of the recommendations which are reducing smoking in pregnancy, risk assessment and surveillance for foetal growth restriction, raising awareness of reduced foetal movements, and effective foetal monitoring during labour. • A driver for the formation of LMS team is to ensure that units work together to drive up safety standards. Due to the small LMS team in Cumbria we will work with the Cumbria and North East maternity network. This relationship needs to have safety at its heart to minimise any variation across sites. There will be continued development of regional clinical governance / risk management policies and processes, with external input into case reviews and shared learning – as well as regional Professional peer reviews. • A national maternity and neonatal quality improvement collaborative has been put in

	place to create the local conditions to improve all aspects of safety. Local Trust champions have been nominated – the trust will be in phase three of the initiative and will participate accordingly. • Multi professional training will be further developed – a full OD and training plan will be developed and implemented. The plan will cover all aspects of OD including MDT working, skills and competencies, multi-site working , culture change and Continuous Improvement • Trust will participate in the Regional peer review system which is now in place • Implementation of midwifery led pathways is well underway • We will review and strengthen joint governance arrangements between maternity and neo-natal care • The trust will continue to review and refine its governance systems to ensure safety and continuous improvement and has developed and is implementing a maternity quality improvement plan • The implementation of better births requires a culture change both within the service and how women interact with it – this will be covered in the OD and training plan.
There should be rapid referral protocols in place between professionals and across organisations to ensure that the woman and her baby can access more specialist care when they need it.	**There will be referral protocols in place and we will gather evidence that this is working. Strong links will be developed with the Neo-Natal Network. (NNN)** • The advice and guidance system will be accessed by midwives which will give them access to advice across a range of specialities • The North Region specialised commissioning team's strategy for neonatal services is to commission a consistent and clear neonatal pathway of care across the geography of the North, to support care as close to home as possible and specialist when needed. Work will be undertaken with the Neonatal Operational Delivery Networks and through them the Local Maternity Systems, to explore more integrated approaches for the delivery of care across the neonatal and wider perinatal pathway. This will include looking at different ways to commission and contract services, to support seamless care pathways and optimise safe and sustainable neonatal care. The neonatal offer will form an integral part of the wider maternity and perinatal pathways and policies within the Local

	Maternity System delivery. • We will work in partnership (commissioners and providers) to review the findings of the Neo Natal review and recent peer review of local services and formulate a detailed local action plan. • An LMS report will be produced by the NNN to ensure that appropriate actions are taken to continuously improve outcomes and the interface between services.. • In North Cumbria we will work with the NNN as we continue to progress with the implementation of our consultation decision. The LMS will work with the Neo-Natal Network to ensure that any change is managed, safety issues addressed and the knock on effect to transport, staffing, capacity considered.
Teams should collect data on the quality and outcomes of their services routinely, to measure their own performance and to benchmark against others' to improve the quality and outcomes of their services.	**Knowledge of quality and outcomes and the wish to improve will be second nature within the service** • The Trust wide performance dashboard has been in place for some time it is reported and actioned within the service and throughout the Trust. • Network wide dashboards are now in place. • The LMS group is looking to further develop specific team level performance dashboards to ensure that professionals understand fully their local area clinical outcomes and effect good local solutions.
BB Objective 4 - Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family	

There should be significant investment in perinatal mental health services in the community and in specialist care.	**We (commissioners and providers) will work with service users to implement the North Cumbria and North East network PNMH end to end pathway which is crucial in ensuring that women who require mental health assessment or treatment get the right care at the right time. It also identifies those women at risk of developing a perinatal mental illness for whom a preventative intervention should be offered.** • We will bid for community services development fund monies to increase the Specialist (secondary care) Perinatal Community Mental Health Team element of our local service and build this into CCG investment plans for the future. • We will develop the application of IAPT services (Improving Access to Psychological Therapies) - working with community hubs. • We will form partnerships with specialist providers to support women with serious mental health conditions as they return to the area. • Our approach will be to target more vulnerable women. • We will work with the MVP and Happy Mums to develop services that fully relate to the needs of women. • A sub group of the LMS board will work on ensuring that the full pathway is in place.
Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby.	**We will ensure mothers have sufficient access to midwives and health visitors postnatally and a consistently high standard of 6 week checks address mums' ongoing health and well being** • In line with feedback via the MVP we will look in detail at the issues raised for women using SCBU and their ongoing care

Maternity services should ensure smooth transition between midwife and obstetric and neonatal care, and when appropriate to ongoing care in the community from their GP and health visitor.	**We will have effective transition between services** • We will develop a continuous pathway of support for women during and following SCBU stay including support for mothers – breastfeeding and post-natal checks. • There are many types of transitions that need to be considered – secondary, tertiary and community care, baby loss transitions, early loss, late loss, bereavement care. • Another aspect to consider is mums who transit from the midwifery-led pathway to a consultant pathway in pregnancy - we know that mums can find this difficult and that there is more likelihood that they have less contact with their named midwife.
BB Objective 5 - Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.	
Multi-professional training should be a standard part of professionals' continuous professional development, both in routine situations in emergencies.	**We will fully develop an effective multi professional team across sites.** • We will maintain and develop further the current multi-disciplinary mandatory training including PROMPT, CTG and NLS. This will be covered in the OD and training plan.

Multi-professional peer review of services should be available to support and spread learning. Providers should actively seek out this support to help them improve, and they must release their staff to be part of these reviews. CQC should consider the issue as part of inspections.	**Multi professional peer review is in place and will develop** • There will be some standardisation of multi-disciplinary learning across the regional network, to include joint learning forums across, as well as the review of and learning from adverse events. • Multi professional training processes and practice, is key to effective multi professional working – this links to the findings of the Morecambe Bay Review. Working between sites and links with tertiary units will be essential to keep local service safe. Multi professional peer review is now available at network level and the trust is fully involved. • The development of information systems that are linked together to give clinicians access to the right information at the right time is key.
BB Objective 6 - Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.	
Providers and commissioners should come together in local maternity systems covering populations of 500,000 to 1.5 million, with shared standards and protocols agreed by all.	**Our LMS is in place and will work with our maternity network and neighbouring LMS to drive up safety standards.** Our LMS is in place – working with the Cumbria and North East Maternity Network to ensure that shared protocols and standards are in place across the wider footprint. A driver for the formation of LMS team is to ensure that units work together to drive up safety standards. Due to the small LMS team in Cumbria we will work with the Cumbria and North East Maternity Network. This relationship needs to have safety at its heart to minimise any variation across sites. There will be continued development of regional clinical governance / risk management policies and processes, with external input into case reviews and shared learning – as well as regional professional peer reviews.

Commissioners should take greater responsibility for improving outcomes, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly.	**Commissioners will work together to ensure that the outcome based end to end maternity pathway is in place** Commissioners (CCG, NHS England and Public Health) will work in partnership with the MVP to utilise the national service specification to refresh the commissioning relationship and re define the service in line with our aspirations and better births recommendations. The emphasis on outcomes will be fully utilised. The outcomes fall into any of the following four categories; • Direct clinical outcomes (e.g., perinatal mortality). • Public health outcomes (e.g., maternal smoking). • Woman-reported outcomes • Process outcomes (e.g. the number of women giving birth in midwifery settings). • The LMS will refresh performance indicators that can be used to determine the effectiveness of services. **Each measure will:** • Be appropriately ambitious (including timescales) though realistic and affordable • Have clarity on service model setting out any required service changes, workforce implications and funding requirements • Describe the support needed from the wider system There is one main provider of maternity services for North Cumbria LMS so there are no significant contractual changes anticipated which are not part of the STP.
BB Objective 7 – A payment system that fairly and adequately compensates providers for delivering high quality care to all woman, whilst supporting commissioners to commission for personalisation, safety and choice	
	We await national guidance

10.0 Financial assessment

- There are some key elements of cost in the LMS maternity transformation plan which will alter the cost base of the service. These include alongside MLUs, continuity of carer, and community hubs amongst other elements
- The STP has a high level plan which covers the changes to health services that were subject to the public Healthcare For The Future consultation (including the maternity model and its supporting infrastructure). This plan was developed to ensure that WNE Cumbria could, over time, provide clinically safe services for the local population within the funding that would be available (i.e. the plans are affordable).
- Within these plans there was not an expectation that changes to maternity services would contribute to the savings target. However, it was acknowledged that having a clearly identified future model for maternity service across WNE Cumbria would be a key element of providing certainty to staff and public and hence be a key enabler to improve recruitment and retention (and hence avoiding premium costs for a number of key staff groups).
- In addition, in assessing the financial challenge facing the system an allowance for the impact of the "Better Births" agenda has been incorporated into the projected cost of addressing clinical standards. It is considered at an STP level that by the end of the planning period the long term staffing (and cost) implication is therefore addressed (along with development in other services).
- However, as the models are further developed the "bottom-up" detailed costing will be incorporated into updated versions of the financial model. For maternity hubs significant development work is required with county council partners to identify both the model and the cost – this will be subject to future business case consideration. Continuity of carer will be assessed when the model is further identified and national guidance is issued. Estimated costings will be undertaken by the end of December 2017.

11.0 IT/ Digital aspirations

Our plan is developing as part of the STP plan and the National plans and will take into account the roll out of national child health system , Technology enabled care (foetal heart monitoring), enabling community midwives to use agile working IT solutions , personal hand held record, use of Apps and electronic prescribing. In addition we need to develop ways of reporting on all elements of the Better Births programme.

Appendix 1

Options considered as part of Healthcare for the Future consultation

Antenatal, postnatal care and home births continue with all options
Penrith Birthing Centre is unaffected.

Option 1 Consultant-led maternity care and AMLUs at CIC and WCH
Option 2 Midwife-led unit only at WCH
Option 3 Full consolidation at CIC

Decision made by CCG Governing Body on 8 March 2017

Following the review of the independently analysed public consultation the CCG Governing body agreed to a recommendation which differed from the preferred option identified in the consultation document.

- Recommendation 2.1: To test the viability of Option 1 over a 12 month period
- Recommendation 2.2: If Option 1 is not proven to be deliverable or sustainable then implement Option 2 at the end of the 12 month period
- Recommendation 2.3: Whilst testing Option 1, to prepare for Option 2 by implementing a Midwifery Led Unit (MLU) in Whitehaven alongside the Consultant Led Unit, in order that the MLU can be audited as if it was freestanding
- Recommendation 2.4: To implement Option 3 if Option 1 is not proven to be deliverable or sustainable and, following audit of the MLU, Option 2 is not deemed to be safe.

Note that the 12 month period stated above has not started as at 31/10/17.

Appendix 2 – Health Needs

Infant Mortality (crude rate of deaths in infants aged under 1 year per 1,000 live births)

The infant mortality rate in districts across WNE Cumbria (2013-15) ranges between 0.8 (Eden) and 3.7 (Allerdale). No district has a significantly different rate from either the Cumbria or England average.
Source: Public Health Outcomes Framework (PHOF), 2013-15. (4.01)

	Count	Rate per 1000
Allerdale	10	3.7
Copeland	5	2.3
Carlisle	15	4.1
Eden	1	0.8
Cumbria	48	3.3
England		3.9

Low Birth Weight

During 2015, the percentage of children born with a low birth weight across the districts across WNE Cumbria (Allerdale, Carlisle, Copeland and Eden) ranged between 2.1% in Allerdale to 4.3% in Copeland (see table below). The percentage of babies born with a low birth weight in Copeland (4.3%) is significantly higher than both the Cumbria (3.0%) and national (2.8%) average.
When you compare the percentage in Copeland to other comparable districts across the country, the value is still an outlier due to being significantly higher than the national average (see table on slide below).

2.01 - Low birth weight of term babies 2015 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	16,748	2.8	2.7	2.8
Cumbria	→	128	3.0	2.5	3.5
Allerdale	→	17	2.1	1.3	3.4
Barrow-in-Furness	→	16	2.3	1.4	3.8
Carlisle	→	37	3.3	2.4	4.6
Copeland	→	28	4.3	3.0	6.2
Eden	→	12	3.4	1.9	5.8
South Lakeland	→	18	2.4	1.5	3.8

Source: Office for National Statistics

Comparative low birth weight data

2.01 - Low birth weight of term babies 2015

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	16,748	2.8	2.7	2.8
Allerdale	→	-	17	2.1	1.3	3.4
Dover	→	1	18	1.7	1.1	2.7
Carlisle	→	2	37	3.3	2.4	4.6
Waveney	→	3	24	2.3	1.6	3.4
Bassetlaw	→	4	22	2.0	1.3	3.0
North Devon	→	5	19	2.4	1.5	3.7
Sedgemoor	→	6	33	2.8	2.0	4.0
Torridge	→	7	14	2.5	1.5	4.1
Newark and Sherwood	→	8	25	2.2	1.5	3.3
Amber Valley	→	9	9	0.8	0.4	1.6
Copeland	→	10	28	4.3	3.0	6.2
Newcastle-under-Lyme	→	11	21	1.8	1.2	2.8
Wyre Forest	→	12	25	2.6	1.8	3.8
North East Derbyshire	→	13	20	2.5	1.6	3.8
Bolsover	→	14	23	2.8	1.9	4.1
Wyre	↓	15	10	1.2	0.6	2.1

Source: Office for National Statistics

Smoking status at time of delivery (% of women who smoke at time of delivery)

During 2015/16, 12.3% of women in Cumbria were recorded as smoking at time of delivery (data not available at district level). This is significantly higher than the national average of 10.6% (however it should be noted that the national data has quality issues, due to the high number of women whose smoking status is not recorded at time of delivery across all Trusts).
Source: PHOF, 2015/16. *data quality issue

	Projected extrapolated from county figure	Percentage
Allerdale	109	12.3
Copeland	88	12.3
Carlisle	147	12.3
Eden	48	12.3
Cumbria	585	12.3
England		10.6*

Breastfeeding

Breastfeeding rates are measured at initiation (when a mother gives birth) and again at 6-8 weeks (through the health visiting service) . The most up to date initiation rates (PHOF - 2014/15) for the districts across WNE Cumbria are shown in the table below. All districts except Eden have rates that are significantly lower than the England average.
The recording of breastfeeding status at 6-8 weeks post birth is poor, which means that data is incomplete for Cumbria. There is a requirement to improve data recording for breastfeeding status at 6-8 weeks.

	Breastfeeding Initiation Rate%
Allerdale	64.8
Copeland	59.2
Carlisle	63.2
Eden	76.2
Cumbria	64.9
England	74.3

Alcohol

In May 2017, Public Health England released its latest local alcohol profiles for England (LAPE). Whilst there is no data specific to alcohol use before, during or after pregnancy, the data does indicate that the rate of hospital admissions due to alcohol related conditions is above the national average in Copeland and Carlisle. The rates of alcohol specific mortality and benefit claims (due to alcoholism) are also significantly above the national average for the Allerdale district. The reported rates in Eden are significantly better than the national average.

	Admission Episodes for alcohol related conditions (narrow) All age per 100,000 2015/16	Alcohol specific mortality Per 100,000 2013-15	Claimants of benefits due to alcoholism per 100,000 2016
Allerdale	667	18.3	177.9
Copeland	709	13.4	167.7
Carlisle	738	9.4	138.3
Eden	564	*	66.5
Cumbria	674	7.8	134.1
England	647	11.5	132.8

Source: PHE LAPE (2017

*number of cases too small to report rate

Healthy weight

The table below provides a summary of the 'excess weight in adult' data. Allerdale, Carlisle and Copeland all have rates of excess weight significantly higher than the national average. Allerdale is now ranked as the district with the highest percentage of adults with excess weight in the whole England.

District	%
Allerdale	71.2
Carlisle	68.0
Copeland	68.8
Eden	65.7
Cumbria	66.9
England	64.8

Source: PHOF 2013-15

Under 18s conception rate (crude rate per 1,000)

Across the districts of WNE Cumbria, under 18 conception rates range from 12.8 (Eden) to 26.5 (Carlisle). No areas have a rate significantly different to either the Cumbria, or the England average.
Source: PHOF, 2015. (2.04)

	Count	Rate per 1000
Allerdale	35	22.4
Copeland	19	17.1
Carlisle	45	26.5
Eden	11	12.8
Cumbria	166	20.8
England		20.8

Vaccination delivery during Pregnancy

Women are advised to be vaccinated against flu and Pertussis (Whooping Cough) during pregnancy. During 2016/17, the target set by NHS England for Flu vaccine coverage during pregnancy was 55%. Cumbria achieved 49.7% coverage during this time period, therefore falling short of the set target. There is evidence to suggest that vaccine uptake rates during pregnancy are improved when community midwives administer the vaccine (rather than pregnant women having to book separate appointments with for example, practice nurses). Currently, hospital and community midwives employed by NCUHT do not administer vaccines to pregnant women

Our Health & Social Care Partners

Cumbria County Council
Cumbria Partnership NHS Foundation Trust
Healthwatch Cumbria
NHS England
NHS North Cumbria Clinical Commissioning Group
North Cumbria University Hospital Trust
North West Ambulance Service
Primary Care including GPs & CHOC
Third and Voluntary Sector
Our Communities
Local Authorities