Please note - This draft plan was awaiting final feedback at time of agenda publication on 30 October 2017. See paragraph 3.6 of the covering report for further information.

APPENDIX 1

Kent and Medway Local Maternity System Transformation Plan

Foreword by Kent and Medway Sustainability and Transformation Partnership

The Kent and Medway (K&M) Local Maternity System (LMS) aligns with the Sustainability Transformation Partnership (STP) and shares the vision of building strong partnerships in order to deliver long term improvements for women, babies and their families. The STP ethos is fully reflected in aims of the LMS in which we feel that by working together, we can build on good ideas further and faster, making improvements for everyone.

Kent and Medway are facing new challenges which means we need to change the way we work and the local maternity transformation plan is an excellent example of this. The demands on maternity services are increasing as our population grows and by creating a local maternity offer we can ensure services are sustainable for the future. Joined up services will increase efficiencies and this is aligned to the broader STP work across Kent and Medway.

The LMS offers an opportunity to understand and plan for the future in a co-ordinated manner and to achieve the ambitions set out in the maternity five year forward view. Similar to the STP, it is the first time that maternity services have worked in this way and it opens up positive ways of making improvements for our local population.

Joint Foreword by the Kent 0-25 Health and Wellbeing Board and the Medway Health and Wellbeing Board

The Kent and Medway Local Maternity System transformation plan sets out an ambitious view for maternity services. Its focus is to ensure that maternity services are delivered in line with the recommendations identified through the national review of maternity services, Better Births. Services must be safe and effective, with a greater degree of patient choice. The LMS will be required to make appropriate links with existing services and pathways of care, whilst developing new work streams to implement the outcomes of the national review. The importance of the work relating to maternity services is acknowledged across Kent and Medway.

As identified in the Marmot Review into health inequalities in England, it is now widely accepted that the foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in pregnancy and early childhood. The physical and mental wellbeing of the mother, foetal exposures in the womb and early childhood experience have lifelong impacts on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status.

The 0-25 Health and Wellbeing Board in Kent and the Health and Well Being Board in Medway endorse this work, particularly when considering reducing variation in services across the locality; the respective Boards are committed to improving health in pregnancy and early childhood. This commitment is reflected in national and local health improvement policy and is reflected in strategies that aim to give every child the best start in life.

The transformation of maternity services across Kent and Medway will be challenging, particularly as it requires genuine joint working across a range of organisations, at a time when finances are challenging and there are a number of competing priorities relating to the local health economy. If the end result is improved services for women, babies and their families, with the creation of seamless pathways and services, then the effort will certainly be worthwhile

Foreword by Dr Brynn Bird - Clinical Lead West Kent CCG

The Kent and Medway Local Maternity System is remapping maternity services to better meet the requirements of women in the future. The changing landscape of the NHS created by the Sustainability Transformation Plans guidance requires a responsive maternity service that is incorporated into a single commissioner model. The LMS has evolved from the Better Births review which focuses on personalised choice, safety and quality. It is consequently recognised that parts of the system are producing different outcomes for women and their families across Kent and Medway in which the LMS will aim to reduce these variations. The LMS will work towards breaking down organisational boundaries to give women a co-ordinated service of care and provide contracting models and payment systems that promote choice.

The system will address risk factors for births in its approach to improve outcomes for women in all demographics of the population with due consideration for neo-natal and peri-natal mental health services. Overall the Local Maternity System will foster a collaborative approach to commissioning through a local maternity offer via clear pathways, service specifications and a single point of access. High standards of training of healthcare professionals will be reflected in specifications to deliver a high quality, sustainable service for women.

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Kent and Medway Local Maternity System

Background

In February 2016 *Better Births* set out the Five Year Forward View for NHS maternity services in England. It set out a compelling view of what maternity services should look like in the future. The vision is clear: *we should work together across organisational boundaries in larger place-based systems to provide a service that is kind, professional and safe, offering women informed choice and a better experience by personalising their care*.

Achieving the vision is as much about changing cultures and creating a lasting ethos of greater collaboration as it is about system design. This will require change in many places and organisations, and also in us as individuals. The potential rewards in terms of outcomes and experience for women, babies and their families will make this effort worthwhile and will lead to maternity services that we can all be proud of.

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

The LMS is the mechanism through which it is expected that the STP will collaboratively transform maternity services, with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes and experience for women, babies and their families. These partnerships have been established across England to develop and implement a local vision for transforming maternity services by 2020/21, based on the principles of the National Maternity Transformation Programme (*Better Births* 2016).

The K&M STP brings together 16 organisations which includes: acute trusts, community trusts, mental health trusts, clinical commissioning groups and upper tier authorities. These are all involved in the planning and provision of health and care services across the region. Together they are focused on how the NHS and social care can work together to improve and join-up services to meet the changing needs of all of the people who live in our area. The STP is a partnership and a new way of working. It ensures that all the health and care organisations in Kent and Medway are working together in a joined-up way and making the best use of the available resources.

Like the STP, the LMS is a partnership rather than an organisation in its own right. The responsibility for commissioning maternity services remains with Clinical Commissioning Groups (CCGs), local authorities and NHS England. However, by working together in this way as part of the STP, the LMS enables local services to become further joined-up and make the best use of the available resources to improve care and outcomes for women and babies.

Local Maternity Systems should be responsible for:

- Developing a local vision for improved maternity services and outcomes based on the principles contained within this plan; which ensure that there is access to services for women and their babies, regardless of where they live.
- Helping to develop the maternity elements of the local sustainability and transformation plans being developed in each area of England.

- Including all providers involved in the delivery of maternity and neonatal care, as well as relevant senior clinicians, commissioners, operational managers, and primary care.
- Ensuring that services are co-designed with service users and local communities.
- Putting in place the infrastructure that is needed to support services to work together effectively, including interfacing with other services that have a role to play in supporting woman and families before, during and after birth.

Following the publication of *Better Births*, K&M decided to apply to become an Early Adopter site. This was the first time many commissioners, providers and stakeholders had met: the only cross Kent and Medway meetings were for Heads of Midwifery and the Maternity Safety Forum. Although the application was unsuccessful, the energy and motivation of all involved was significant and it was decided that we should become a LMS as soon as possible, in order to drive the work forwards across our footprint. This was despite having not received acknowledgement from the Kent and Medway STP at this point. The K&M LMS was subsequently created in December 2016.

This speedy start to establishing the Kent and Medway LMS demonstrated a significant commitment from all of the membership at a time when many had not heard of the importance of maternity transformation. The LMS meet on a bi-monthly basis and the membership continues to evolve.

The Kent and Medway LMS, via the WHAM (West Kent CCG, High Weald Lewes Havens CCG and Maidstone and Tunbridge Wells Trust) pilot, are one of seven national 'Materntiy Choice and Personalisation Pioneers' developing and testing ways of improving maternity services for women.

The Maternity Choice and Personalisation Pioneers have been implemented to test ways of improving choice and personalisation for women accessing maternity services. All of the Pioneers will seek to deepen as well as widen the choices available to women across clinical commissioning group (CCG) boundaries, by seeking to attract new providers of services into their areas and empowering women to take control in decisions about the care they receive, to meet their needs and preferences. Part of this work is to ensure women receive the good quality, consistent information needed to make informed choices at each stage of their maternity pathway, whilst ensuring they are taking control through personal maternity care budgets.

Supported by NHS England and other partners, the Pioneers will work rapidly over an 18 month period. NHS England will draw on this work and promote it for national adoption and adaptation as the Pioneers progress, to support all areas of the country to offer personalised maternity care tailored to women's needs and preferences. The aims of the pilot are outlined in more detail further on in this document.

Who is Leading the Development of the Plan?

Transformation Development and Delivery includes:

- 8 x Kent and Medway CCGs
- 4 x Kent and Medway Acute Trusts
- Kent County Council
- Medway Council
- NHSE Public Health Screening and Immunisation services
- Women and their families

CCG	Lead Commissioner	NHS Trust	Head of Midwifery	Clinical Director	Labour Ward Lead	Safety Champion
Dartford, Gravesham and Swanley CCGs	Amanda Kenney	Dartford and Gravesham NHS Trust	Deborah McAllion	Mr Abhishek Gupta	Mr Atef El-Matary	Mrs Joanne Seymour
East Kent CCGs	Claire Haywood	East Kent Hospitals University NHS Foundation Trust	Helen Bland	Mr Graham Ross	Mr Niyi Agboola-Ashford Mrs Keyuri Shrotri-Margate	Sally Smith
West Kent CCG	Natalie Manuel	Maidstone and Tunbridge Wells NHS Trust	Jenny Cleary	Mr Rowan Connell	Miss Shazia Nazir	Rachel Thomas
Swale CCG	Amanda Kenney	Medway NHS Foundation Trust	Dot Smith	Mr Hany Habeeb	Mr Robin Edwards	Kate Harris
Medway CCG	Michael Griffiths					

Contractual Arrangements across K&M

CCG	TRUST	CONTRACT
Dartford, Swanley and Gravesham CCG, Swale CCG	Dartford and Gravesham NHS Trust	Standard NHS PBR Contract
East Kent CCGs	East Kent Hospitals University Foundation Trust	Standard NHS PBR Contract
West Kent CCG	Maidstone and Tunbridge Wells NHS Trust	Aligned Incentive
Medway CCG	Medway NHS Foundation Trust	Standard NHS PBR Contract

Current Configuration of Local Services

Kent and Medway currently offer all 3 types of birth place: Homebirth, birth centre and obstetric unit birth. The risks and benefits are discussed with women who proactively make informed decisions and choices concerning their care. The current homebirth across the area ranges from 2-3%.

STP Footprint	CCGs	Acute Trust	Obstetric Led Unit	Midwifery Led Unit	Satellite Day Care/Enhanced Care Unit	NICU/SCBU	Community Trust	Mental Health Trust	Local Authority	Ambulance Service
Kent and Medway	Ashford	East Kent Hospitals University NHS Foundation Trust	William Harvey Hospital	William Harvey Hospital- Co Located	2	Level 3 NICU/SCBU	Kent Community Health NHS Foundation Trust	Kent and Medway NHS Health and Social Care Partnership Trust	Kent County Council	SECAMB
	Canterbury									
	South Kent Coast		Queen Elizabeth the Queen Mother	Queen Elizabeth the Queen Mother- Co-Located		Level 1				
	Thanet									
	Dartford, Gravesham and Swanley	Dartford and Gravesham NHS Trust	Darent Valley Hospital	Darent Valley Hospital- Co-Located	0	Level 1 SCBU				
	Swale									
	West Kent	Maidstone and Tunbridge Wells Trust	Pembury Hospital	Crowborough Birth Centre- Free Standing	2	Level 2 NICU/SCBU		North East London Foundation Trust (Under 18)		
				Maidstone Birth Centre- Free Standing						
	Medway	Medway Foundation Trust	Medway Maritime Hospital	Medway Maritime Hospital- Co-Located	1	Level 3 NICU	Medway Community Health Care		Medway Council	

The Kent and Medway Local Maternity System is co-terminus with the Kent and Medway STP footprint. The terms of reference are included below.

K&M LMS ToR v5.docx

Mission Statement

To transform maternity services in Kent and Medway in line with the recommendations set out in Better Births, resulting in improving outcomes for women, their babies and families. Kent and Medway will provide safer, more personalised care by bringing together commissioners and providers in the area.

Caveat: this document will be used as a working document throughout the transformation

Aims

The K&M LMS are a group of dedicated and motivated professionals, stakeholders and service users working together as a collaborative to improve the lives of women and babies through the transformation and the implementation of safe, personalised, professional and high quality maternity services. The K&M LMS are the agent for the delivery of Better Births, in line with the Five Year Forward View and we will provide the planning and leadership for the transformation of Maternity services throughout our STP footprint. The Kent and Medway LMS includes all providers and commissioners of maternity and neo-natal care in our footprint, and it is our ambition to have a clinical lead as Chair for our LMS.

The K&M LMS will work closely with service users and their families in order to ensure that co-production is at the heart of what we do. In order to do this effectively, there will be a work stream dedicated to the creation of and support for Maternity Voices Partnerships (MVP). We will take care to ensure that our MVP is representative of the varied local communities throughout Kent and Medway and we will use this voice to assist with the design, implementation and review of maternity services.

As a LMS, we will develop a local vision for improved maternity services and outcomes, and base this on the recommendations contained in Better Births and guidance shared from NHSE (*Implementing Better Births – a resource pack for Local Maternity Systems*). It is our ambition to ensure that there is access to a consistent Maternity Local Offer across our footprint, regardless of where service users live in Kent and Medway. The LMS will work together across organisational boundaries in a large place based system, to ensure that women, babies and families are able to choose and receive the services they need within their communities, near their homes. Women will be offered an informed choice and a better experience through personalised care. This will reduce variation and inequity across the STP footprint.

The LMS will support putting structures into place to assist services to work together effectively. This will include interfacing with other services (such as those in the voluntary sector) that have a role in supporting women and families before, during and after the birth of their baby.

It is our intention to work alongside the Kent and Medway STP Board to ensure that the maternity elements of the STP are being developed in line with the recommendations in Better Births and national guidance.

Initially, the LMS will be responsible for the strategic direction for maternity services across the Kent and Medway footprint. However, it is our ambition that that the LMS will work together towards becoming the single commissioner for maternity services in Kent and

Medway. This will involve the implementation of a new national service specification for maternity and an aspiration for a single contract for maternity services across the Kent and Medway footprint.

Current Kent and Medway Maternity Landscape

The population of Kent and Medway is approximately 1.5 million with a mixed socio – economic picture. The Thanet CCG area is Kent's most deprived local authority district. There is a mixture of urban and rural geography with many women living in villages which are relatively isolated from the main population centres. These women and families have further distances to travel in order to access services.

There are significant health inequalities across Kent and Medway. In the Thanet CCG area, one of the most deprived areas of the county, a woman living in the best ward for life expectancy can expect to live almost 22 years longer than a woman in the worst. Each district within Kent and Medway has areas with poor health outcomes and there are also areas with high deprivation, poor levels of educational attainment and high crime rates.

The following information is taken from the Kent Maternity Needs Assessment (March 2017) and has been provided by NHS Medway CCG and Medway Council. The data does not take account for planned housing developments across Kent and Medway (unless indicated).

Population

Across Kent, the number of females aged between 15 and 44 in 2014 was 277,274 and is expected to be 296,447 by 2039, an increase of 6.9%. This increase varies across CCGs, with the biggest percentage increase expected in Dartford, Gravesham and Swanley, at 12.8%.This represents an additional 6,400 women of child bearing age. The number of women aged 15 to 44 is expected to decrease in South Kent Coast CCG between 2014 and 2020. While the number of women in this age group does increase again, there is an anticipated 925 fewer women aged 15 to 44 in 2039 compared to 2014.

There were approximately 276,492 people resident in Medway in 2015, according to figures produced by the Office for National Statistics.

The 2015 mid-year population estimate shows an increase of 12,567 (4.8%) from the 2011 Census (263,925), and an increase of 27,004 (10.8%) since the Census in 2001 (249,488).

Compared to England the population of Medway has a smaller proportion of people over the age of 65 years (Medway 15.4% and England 17.7%). Medway has a larger proportion between the ages of 0 and 14 years than England (19.1% and 17.9% respectively) and between the ages of 15 and 24 years (10.4% and 9.7% respectively). The population of Medway is therefore younger than the population of England overall.

Social and Economic Deprivation

The Index of Multiple Deprivation 2015 (IMD 2015) is the official measure of relative deprivation for small areas in England. The below chart is a benchmarking tool for the South East region which shows Kent is better than the England average at 18.4 for deprivation and Medway is worse at 21.4.

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Indicator	Period	England	South East region	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
Deprivation score (IMD 2015)	2015	21.8	-	10.5	23.4	9.8	18.8	11.9	23.1	18.8	22.3	18.0	11.5	27.1	19.3	22.9	26.9	9.4	10.2	14.0	8.9	5.7
Children in low income families (under 16s)	2014	20.1	14.7	10.8	17.9	10.8	16.5	11.8	21.2	16.4	21.4	18.3	11.6	24.0	18.7	19.4	23.4	10.8	10.1	13.0	9.3	7.0
Statutory homelessness	2015/16	0.9	0.8*	0.3	2.7	0.6*	*	0.2*	3.6	*	3.1	0.1	0.3*	0.6	0.8	0.6	*	0.2*	0.7	0.6*	*	0.6
GCSEs achieved	2015/16	57.8	60.3	55.9	60.3	67.2	59.1	61.2	45.0	58.7	58.5	54.9	59.5	53.2	52.1	59.4	53.0	65.6	61.1	59.3	69.7	70.9
Violent crime (violence offences)	2015/16	17.2	16.8	9.7	22.7	10.4	15.4	18.1	24.6	18.4	22.7	15.2	10.7	35.4	20.9	20.1	34.0	13.9	10.5	14.7	12.2	7.2
Long term unemployment	2016	3.7*	2.9*	1.2*	2.5*	1.3*	2.9*	1.2*	3.4*	3.2*	5.6*	2.9*	0.7*	2.8*	2.8*	2.2*	2.3*	0.9*	1.0*	1.5*	1.0*	0.8*

Source: PHE Fingertips Health Profiles
https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/3007000/pat/6/par/E12000008/ati/102/are/E10000016

General Fertility Rate

The General Fertility Rate (GFR) is the number of live births per 1,000 women aged between 15 and 44 years. The GFR across Kent increased between 2006 and 2012, from 56.4 births per 1,000 population to 65.1. Since then the rate has decreased, and was 62.2 live births per 1,000 females aged 15 to 44 in 2015.

This ranged from 43.8 in Canterbury and Coastal CCG to 69.7 in Swale CCG. Ashford (66.9), Dartford, Gravesham and Swanley (68.1), Swale and Thanet (69.1) CCGs had a significantly higher GFR than Kent, while Canterbury and Coastal had a significantly lower rate.

The general fertility rate in Medway in 2015 was 65.2 births per 1,000. This value is higher than South East region and England averages (61.7 and 62.5 births per 1,000 respectively). In Medway, the GFR varies considerably between electoral wards, ranging from around 48 in Rainham Central to 79 in Luton and Wayfield.

Births

Number of live births by Trust (2010-2015)

Trust	2010	2011	2012	2013	2014	2015
Dartford and Gravesham NHS Trust	3861	4934	5187	4751	5014	5091
East Kent Hospitals University Foundation Trust	7444	7346	7504	7022	6976	7049
Maidstone and Tunbridge Wells NHS Trust	5388	5580	5723	5432	5735	5868
Medway NHS Foundation Trust	4836	4887	5205	4930	4911	4922

Data provided by Trusts

Population Increase

The Kent and Medway population is set to grow rapidly and surpass Office of National Statistics (ONS) predictions. There are ambitious housing expansions planned throughout the STP footprint. The population is expected to grow by 90,000 people (5%) over the next 5 years; 20,000 of these people will be housed in the new town being built in Ebbsfleet. The Ebbsfleet Garden City will develop over the next 15 years as up to 15,000 homes are built.

The Kent and Medway Growth Infrastructure Framework (KMGIF) has predicted 188,200 new homes and 414,000 more people (by 2031) incremental to ONS predictions. It is expected that the new population will put pressure on Maternity and paediatric services especially. This will also not be evenly distributed across Kent and Medway, consequently putting more pressure on some units than others.

The projected population increase arising as a result of the housing development in some parts of Kent, will need to be accounted for in order to ensure that maternity services are able to cope with the likely increased demand in the future.

The population projections outlined in the table below are produced by the ONS, and do not take into account planned housing developments:

Projected female population aged 15 to 44

	2014	2020	2025	2030	2035	2039
NHS Ashford	22731	22968	23802	24304	24624	24827
NHS Canterbury and Coastal	40577	39497	40235	41396	41625	41944
NHS Dartford, Gravesham and	50001	51246	53372	54669	55617	56407
NHS Medway	55235	56621	58572	60322	61639	62460
NHS South Kent Coast	34022	32566	32951	33020	33085	33097
NHS Swale	20513	20739	21539	21978	22393	22640
NHS Thanet	24045	24195	25140	25644	26080	26308
NHS West Kent	85385	85215	87898	89301	90484	91224
Kent & Medway	332509	333045	343509	350635	355547	358906

Source: ONS population projections, prepared by KPHO (RK), 8/17

The below table demonstrates the expected birth increase across all Kent and Medway CCGs over the next 5 years taking into account housing developments:

Population Prediction (Births)							
CCG Name	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
NHS Ashford CCG	1515	1546	1567	1572	1592	1604	1616
NHS Canterbury and Coastal CCG	1917	1919	1916	1935	1934	1930	1926
NHS Dartford, Gravesham and Swanley CCG	3411	3476	3510	3554	3573	3600	3621
NHS Medway CCG	3592	3645	3693	3742	3763	3792	3817
NHS South Kent Coast CCG	2148	2161	2173	2176	2177	2178	2177
NHS Swale CCG	1430	1450	1472	1480	1486	1492	1499
NHS Thanet CCG	1624	1654	1663	1672	1680	1686	1693
NHS West Kent CCG	5507	5579	5644	5695	5766	5818	5862
Total	**21143**	**21430**	**21636**	**21826**	**21970**	**22100**	**22212**

Provided by South East Quality Observatory

Workforce

In 2016, the Royal College of Midwives released the 'State of Maternity Services' report. The report highlighted that the number of midwives working in the NHS in England has risen by 1500 since 2010. However, when looking at the age profile of these midwives it is apparent that the number aged over 50 increased, and one in three midwives in England (32%) are now in their fifties and sixties. Older midwives bring a benefit in their skills and knowledge, but it is a significant concern that such a large proportion of the midwifery workforce is so near to retirement. As a result, more midwives require training, and in a timely manner, so they can benefit from the experience from their more senior colleagues before they retire. Despite a shortage in midwives, in the 12 months to September 2016, the NHS midwifery workforce in England rose by just 104. From autumn 2017, Midwifery students will no longer receive the training bursary and will be eligible for the full cost of tuition fees. The effect of this change is unknown at present.

In Kent and Medway, the LMS feel that there is a significant risk of there being an issue with the recruitment of midwives, particularly in the light of the projected population increase in the coming years, the local scale of which is challenging to predict. The LMS, as a core element of the STP, will be required to give consideration as to how this likely pressure can be safely managed in the context of maternity transformation.

Current birth ratio, turnover and vacancy in the Kent and Medway LMS:

NHS Trust	Midwife : Birth Ratio 1 : 28 (National recommendation)	Staff Turnover %	Current Vacancies
DVH	1 : 35 pure 1 : 32 (90:10 skill mix applied)	9.74%	Minus 2.33 WTE B 5/6 and 2.07 WTE B7
EKHUFT	1:31	12.51%	6.73WTE B6 8.99WTE B5
MTW	1 : 29	8.20%	9WTE
MFT	1 : 28	7%	15.04 WTE

A further RCM report 'Why Midwives Leave – Revisited' (October 2016) asked midwives who have left the profession their reasons for leaving. The top five reasons that midwives were not happy/satisfied were:

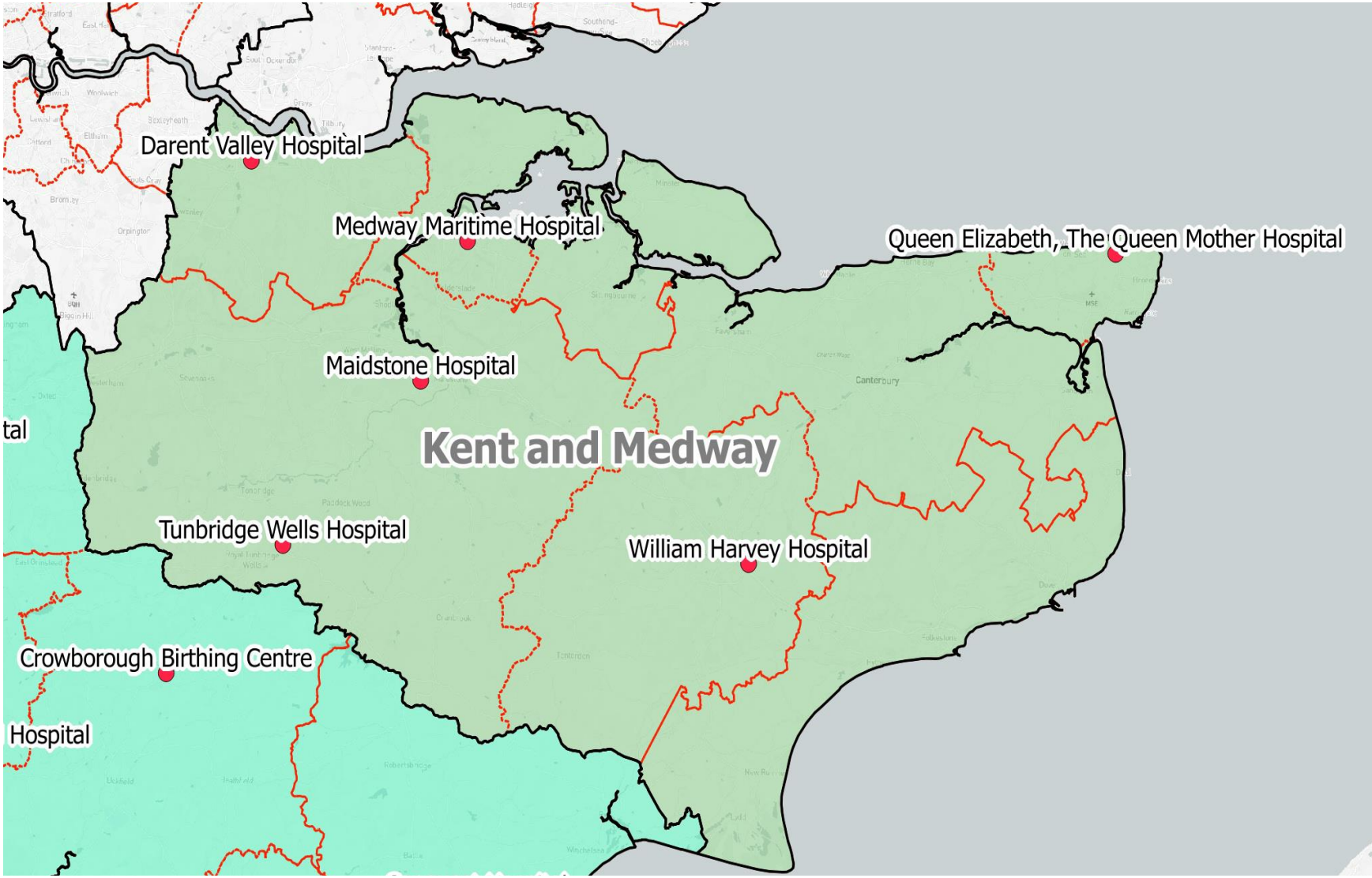
- Staffing levels at work (52%)
- Quality of care they were able to give (48%)
- Workload (39%)
- Support they were getting from their manager (35%)
- Working conditions (32%)

In Kent and Medway, informal information collected from the Heads of Midwifery suggests that the reasons for leaving midwifery are varied and explanations such as completing Health Visitor training, culture, retirement (and then being available to do flexible bank work), not returning after maternity leave, promotion or moving to a job nearer home were all stated.

All Trusts and Heads of Midwifery in Kent and Medway have signed up to the RCM's 'Caring for You' campaign. This aims to improve the health, safety and wellbeing of RCM members at work, so they are able to provide high quality care for women and their families. By signing the Caring for You Charter, a commitment to improve the health, safety and wellbeing of midwives, student midwives and maternity support workers has been made. The LMS is supportive of this commitment and will encourage ongoing involvement in the campaign.

The workforce subgroup of the Kent and Medway LMS will need to focus on current and future recruitment and retention challenges, carrying out scoping and work which will look at this in detail. This may include following some of the recommendations made by the RCM ('Why Midwives Leave – Revisited 2016') such as a review of maternity staffing levels using a recognised workforce planning tool (such as Birthrate Plus) and an ongoing review of maternity turnover rates and vacancy data across the whole footprint. The LMS recognise that it will be essential to have local providers of Higher Education (such as Canterbury Christ Church University and the University of Greenwich) present for these pieces of work in addition to Health Education England (HEE).

Provider and Commissioner Landscape



Dartford & Gravesham NHS Trust

The Facilities

Dartford and Gravesham NHS Trust, is one of the main acute healthcare providers in the West Kent area. It offers maternity provision to high and low risk pregnant women in three models of care:

- Traditional community care with a home birth service
- Co-located midwifery led birthing unit
- Low and high risk traditional hospital care

The service is centralised in Darent Valley Hospital, Dartford, with women choosing delivery booked under the care of the midwife/ shared care or with the consultant obstetrician. Delivery is planned via the teams at Darent Valley Hospital, which offers the facilities of a home birth, co-located midwifery led unit, Delivery Suite, obstetric theatres and Special Care Baby Unit.

Darent Valley Hospital is a single site hospital that has the maternity unit based in the west wing. The facilities currently available on Level 3 include:

- Delivery Suite with 8 en-suite delivery rooms, a high dependency room, 2 bedded recovery area and two obstetric theatres. It provides intrapartum care to high and low risk women. This is a 24 hours a day, 7 days a week service.
- A 20 bedded maternity ward (Cedar Ward) providing care to high risk antenatal and postnatal women. This is a 24 hours a day, 7 days a week service.
- A fetal assessment unit (Tambootie Ward) - with 2 couches and 2 chairs providing high risk, day care surveillance to antenatal women. This is a 7.5 hours a day, 5 days a week service.
- A maternity triage facility (Tambootie Ward)- with 2 cubicles, 2 couches and 2 chairs providing triage, assessment , advice and a plan of care to women above 36 weeks gestation. This is a 24 hours a day, 7 days a week service.
- A co-located midwifery led unit (Aspen Ward) which has 4 birthing rooms, facilitates for water births and 12 low risk postnatal beds. This provides intrapartum and immediate postnatal care to low risk women. It also supports the care of women during the postnatal period who have previously been deemed to be high risk.
- From the 1st April 2011, the needs of women on the Transitional Care Unit will be coordinated from the Special Care Baby Unit. This is a 24 hours a day, 7 days a week service.
- Antenatal clinic and the Ultrasound Department are based on level 2. Consultant and midwifery led services are held in this facility. This is a 7.5 hours a day, 5 days a week service.
- Community midwifery care and clinics are held in a variety of settings including Children's Centres, GP surgeries and the woman's own home. This service runs between 08.30 and 17.00 hours (7 days per week), outside of these hours an on call service is provided.

To date, Dartford and Gravesham NHS Trust has succeeded in accommodating the increase in birth rate and this is largely due to a capital investment in facilities of £1.3 m. The opening of the Maternity Triage area helped greatly in addressing capacity problems, by relieving pressure on Delivery Suite beds.

Clinical Activity

The table below shows the key clinical activity findings occurring at Dartford and Gravesham NHS Trust up to 31st March 2017-rolling full year effect. It demonstrates that midwifery activity is wide across the hospital and community settings. Previous data 2015/2016 is shown in (brackets).

<table>
<tr><td>Birth Totals</td><td>Total women delivered= 4932 (5069)
Total Babies delivered= 5003 (5142)</td></tr>
<tr><td>Place of Birth</td><td>Hospital= 4816 (4955) of which MLU= 763 (794) and Delivery Suite= 4053 (4161)
Out of Hospital= 116 (114) of which Home=58 (53) and BBA= 58 (61)</td></tr>
<tr><td>Distribution in %</td><td>Delivery Suite= 82.18% (82.09%) MLU= 15.47% (15.67%)
Home= 1.18% (1.05%) Other places=1.18% (1.19%)</td></tr>
<tr><td>Populations</td><td>Kent= 61.3% Bexley= 28.5% Essex= 2.9% Greenwich = 2.7%
Medway= 2.3% Others= 2.3%
(Correct at November 2016)
Kent women- 3023
Medway women 113
Out of area 1796</td></tr>
<tr><td>Bookings</td><td>Total women booked= 5925 (5754)
Approx. 83.2% (88%) of all bookings result in birth with DVH continuing care.
16.8% (12%) are pregnancy loss/move out of area.</td></tr>
<tr><td>Case Mix</td><td>This assessment of the case mix, arising from the intrapartum episode, as shown below:
<table>
<tr><th>Categories I – III</th><th>Categories IV – V</th></tr>
<tr><td>65%</td><td>35%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Movement of Women before and after birth</td><td>The annual hospital births are 4874 (5016) (inc BBA) and 58 (53) at home.

Of the births, approximately 7%, 345 (351) women per annum are transferred postnatally to a neighbouring maternity service and have usually received their community care locally (exports), so this number is deducted from the total births.

Approx. 97 (2%) women are seen by the community staff having birthed elsewhere (imports), so this number is added to the annual community cases and totals 4684 (4718).

<table>
<tr><th>Case Mix</th><th>Hospital/BBA births</th><th>Home births</th><th>Exports</th><th>Imports</th></tr>
<tr><td>65% low risk

35% high risk</td><td>4932 (5016)</td><td>58 (53)</td><td>345 (7%)</td><td>97 (2%)</td></tr>
</table>
</td></tr>
<tr><td>Antenatal Contacts</td><td>Each pregnant woman receives between 7-10 contacts in pregnancy. This totals approx. 32,788 up to 46,840 antenatal appointments (33,026 up to 47,180).</td></tr>
<tr><td>Postnatal Contact</td><td>Each newly delivered woman receives an average of 3 contacts in the postnatal period. This totals approx. 14,052 (14,154) postnatal visits.</td></tr>
</table>

Category	Process/Outcome indicators
Category I	This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if: The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.
Category II	This is also a normal outcome, very similar to Category I, but usually with a perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention.
Category III	Moderate risk/need such as Induction of Labour with Syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/ or Syntocinon will become a Category IV.
Category IV	More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.
Category V	This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

East Kent University NHS Foundation Trust (EKHUFT)

The Facilities

Maternity services within East Kent Hospitals University Foundation Trust are provided over 800 square miles, which make this Trust one of the largest in the UK. Maternity services are provided on 4 sites and in the surrounding community areas. There is a staff group of approximately 280 midwives providing maternity care across the Trust and the Trust has a birth rate of approximately 7400 births per year.

Maternity services are provided in the following areas:

The William Harvey Hospital

- Based in Ashford in Kent. It is a consultant led unit with 28 antenatal/post-natal ward (Folkestone ward). The labour suite has 9 labour rooms, 1 pool room and 3 Induction of labour rooms, there is an obstetric operating theatre, on the labour ward and the labour ward is in close proximity to the main operating theatre. A maternity day care area provides day care and fetal medicine consultant clinics. Routine consultant led antenatal clinics are held in the out-patient department.
- The Singleton Midwifery led unit is situated on a floor below the main labour ward and has 7 beds with 2 water birth rooms.
- The level 3 neonatal intensive care unit (NICU) which has 7 intensive care cots, 4 high dependency cots and 14 special care cots. This is a regional unit that accepts sick and preterm babies from the local area and participates in the Emergency Bed Bureau offering cots to other areas when necessary.

Queen Elizabeth the Queen Mother (QEQM) Hospital

- Based in Margate in Kent. It is a consultant led unit with 22 antenatal/post-natal beds (Kingsgate ward). The labour ward has 7 labour rooms plus 1 pool room and an induction of labour bay which has 3 beds. There is an obstetric operating theatre on the labour ward and main theatre is located in the theatre complex. Day care and consultant led clinics are held in St Nicholas suite (just off Kingsgate ward).
- The St Peters Unit is adjacent to Kingsgate ward and is a midwifery led unit with 4 labour/birth/and postnatal beds; two of these rooms have pools.
- The level 1 special care baby unit (SCBU) has 2 high dependency beds and 12 special care cots unit.

There are 2 satellite maternity centres, in Kent and Canterbury Hospital and Buckland Hospital in Dover, which provide outpatient day care services and post-natal support services. Services are provided on these sites seven days a week 9am- 5pm

Community maternity services are provided in 104 children's centres primarily, but also GP surgeries, and in women's homes across the Trust. There are 10 community teams covering the patch and each team offers a homebirth service at all times.

Clinical Activity

The table below shows the key clinical activity findings occurring up to 31st March 2017-rolling full year effect.

<table>
<tr><td>Birth Totals</td><td>Total women delivered= 6,719
Total Babies delivered= 6,853</td></tr>
<tr><td>Place of Birth</td><td>William Harvey Hospital: 3082 William Harvey MLU: 761
QEQM Hospital: 2283 QEQM MLU: 500
Home Births: 227</td></tr>
<tr><td>Distribution in %</td><td>Delivery Suite= 78.0%
MLU= 18.3%
Home= 3.1%
Other places=0.5%</td></tr>
<tr><td>Populations</td><td>Kent= 6,755
Bexley= 3
Essex= 3
Greenwich = 0
Medway= 7
Others= 85</td></tr>
<tr><td>Bookings</td><td>Total women booked= 7,744
Approx. of all bookings result in birth with continuing care: 88.4%
11.6% are pregnancy loss/move out of area</td></tr>
<tr><td>Case Mix</td><td>This assessment of the case mix, arising from the intrapartum episode, as shown below:
<table><tr><th>Categories I – III</th><th>Categories IV – V</th></tr><tr><td>46.2%</td><td>53.8%</td></tr></table></td></tr>
</table>

<table>
<tr><td>Movement of Women before and after birth</td><td>The annual hospital births are 6,641 (96.9%) and 212 (3.1%) at home.

<table><tr><th>Case Mix</th><th>Hospital/BBA Births</th><th>Homebirths</th><th>Exports</th><th>Imports</th></tr><tr><td>Low Risk 46.2%

High Risk – 53.8%</td><td>6,641</td><td>212</td><td></td><td></td></tr></table></td></tr>
<tr><td>Antenatal Contacts</td><td>Each woman receives on average 9.6 antenatal appointments, giving an average of 74,342 appointments per year.</td></tr>
<tr><td>Postnatal Contact</td><td>Each woman receives on average 3 postnatal appointments, giving an average of 20,559 appointments per year.</td></tr>
</table>

Maidstone and Tunbridge Wells NHS Trust

Facilities

The Maternity services Maidstone & Tunbridge Wells NHS Trust (MTW) provides care to high and low risk pregnant women on 3 sites of
2 freestanding birth centers:

- Crowborough
- Maidstone

The site at Pembury obstetric provides both midwifery and obstetric services and a level 2 neonatal unit traditional community services with a home birth service is also part of the service - covering large part of West Kent, along with parts of East Sussex

Crowborough Birthing Centre is a midwife-led service. The Centre has two birthing rooms and three postnatal rooms, two of the bedrooms have double beds so that partners can stay.

Maidstone Birth Centre facilities include 2 birth rooms, 4 postnatal rooms, a kitchen / diner, a garden area and antenatal areas. There is also a parent education room and 2 antenatal consulting rooms

Both birth centres are open 24 hours, 7 days a week. They are staffed by a core team of dedicated midwives and maternity support workers who work in partnership with community midwives to provide seamless midwifery led care throughout pregnancy, labour and following the birth. Birthing pools are available at both centres and the midwives are sympathetic to alternative therapies such as acupuncture and aromatherapy

Locally based community midwives work from the birth centres doing bookings, ante natal care which helps encourage women to consider this as choice for place of birth at an early stage of pregnancy. Collaborative working continues throughout the pregnancy and postnatally.

Maidstone also has obstetric ante natal clinics and scanning services

Pembury services include:

Ante natal clinic for both midwifery and obstetric care

Maternity Day Unit – Monday to Friday 8-6

Triage – open 24 hours a day for any women seeking advice, assessment and a plan of care to women

Ante natal ward providing care to high risk antenatal and postnatal women. This is a 24 hours a day, 7 days a week service.

Delivery Suite consists of 18 en-suite delivery rooms, 2 high dependency rooms, 2 bedded recovery area and two obstetric theatres. It provides intrapartum care to high and low risk women. This is a 24 hours a day, 7 days a week service.

Post-natal ward is available 24 hours , 7 days a week, this includes beds for women and their babies requiring Transitional care, also a 24 hours a day, 7 days a week service.

Community midwifery care and clinics are held in a variety of settings including Children's Centres, GP surgeries and the woman's own home. This service runs between 08.30 and 17.00 hours (7 days per week), outside of these hours an on call service is provided.

Clinical Activity

The table below shows the key clinical activity findings occurring at MTW up to 31st March 2017- rolling full year effect.

<table>
<tr><td>Birth Totals</td><td>Total women delivered=5977
Total Babies delivered= 6071</td></tr>
<tr><td>Place of Birth</td><td>Tunbridge Wells Hospital - 5274
Crowborough- 160
Maidstone- 492
Home- 144
Community births - 13% (803 women)
TWH at Pembury - 87%</td></tr>
<tr><td>Distribution in %</td><td>Community births - 13% (803 women)
TWH at Pembury - 87%</td></tr>
<tr><td>Populations</td><td>Kent= 84.42% Medway= 0.69% Others= 14.89%
(NHS High Weald Lewes Havens CCG 10.36%)</td></tr>
<tr><td>Case Mix</td><td>This assessment of the case mix, arising from the intrapartum episode, as shown below:
<table><tr><th>Categories I – III</th><th>Categories IV – V</th></tr><tr><td>47%</td><td>53%</td></tr></table></td></tr>
</table>

Medway Foundation Trust

The Facilities

Medway NHS Foundation Trust is one of the main acute healthcare providers in the North Kent area. It offers maternity provision to high and low risk pregnant women in three models of care:

- Traditional community care with a home birth service
- Co-located midwifery led birthing unit
- Low and high risk traditional hospital care

The service is centralised in Medway Maritime Hospital, Gillingham, with women choosing delivery booked under the care of the midwife/ shared care or with the consultant obstetrician. Delivery is planned via the teams at Medway Maritime Hospital, which offers the facilities of a home birth, co-located midwifery led unit, Delivery Suite, obstetric theatres and Level 3 Neonatal Unit.

Medway Maritime Hospital is a single site hospital that has the maternity unit based in the level 2 and 4, Green Zone. The facilities currently available include:

- Delivery Suite with 10 en-suite delivery rooms, two high dependency beds, , a postnatal home from home bereavement suite, a 2 bedded recovery area and two obstetric theatres. It provides intrapartum care to high and low risk women. This is a 24 hours a day, 7 days a week service.
- A 24 bedded postnatal ward (Kent Ward) providing care to low risk postnatal women. This is a 24 hours a day, 7 days a week service.
- A 23 bedded high risk antenatal ward (Pearl Ward) including a 7 bedded transitional care unit for babies who need support from the neonatal team but who are well enough to stay with mum. The needs of women on the Transitional Care Unit are coordinated from the Special Care Baby Unit. This is a 24 hour a day, 7 days a week service.
- Team Maia is the induction team who support the induction of labour pathway which includes pre-assessment, and commencement of the induction plan. This is a 7 day service.
- Team Aurelia is the elective caesarean team who support the elective caesarean pathway which included pre-assessment and support during the birth. This is a 5 day service.
- A fetal assessment unit (Harris Birth right Centre) providing advanced ultrasound scanning and invasive treatments and high risk pregnancy clinics. This is a 7.5 hours a day, 5 days a week service.
- The Maternity care unit (MCU) is a day case referral centre offering fetal maternal assessment and monitoring. This is a 7 day service
- A maternity triage facility (within Delivery Suite), with two cubicles, providing triage, assessment, advice and a plan of care to women. This is a 24 hours a day, 7 days a week service.
- A co-located midwifery led unit (The Birth Place) which has 5 en-suite birthing rooms, including two plumbed in pools and all with double beds to support partners stay. There are four postnatal beds. This provides intrapartum and immediate postnatal care to low risk women.
- Antenatal clinic providing consultant and midwifery led services. This is a 7.5 hours a day, 5 days a week service.
- Community midwifery care and clinics are held in a variety of settings including Children's Centres, GP surgeries and the woman's own home. This service runs between 08.30 and 17.00 hours (7 days per week), outside of these hours an on call service is provided. The Community teams support a 24 hour 7 day a week home birth service.

Clinical Activity

The table below shows the key clinical activity findings occurring at Medway Foundation trust up to 31st March 2017-rolling full year effect. It demonstrates that midwifery activity is wide across the hospital and community settings.

<table>
<tr><td>Birth Totals</td><td>Total women delivered= 5060

Total Babies delivered= 5161</td></tr>
<tr><td>Place of Birth</td><td>Hospital = 4992 of which MLU= 841 Delivery Suite=2392 Theatre =1659 other sites = 100

Outside = 169 of which Home=161 and in transit or en route = 8

Birth Before Arrival=58</td></tr>
<tr><td>Distribution in %</td><td>Delivery Suite=81% MLU=17% Home=3%</td></tr>
<tr><td>Populations</td><td>Medway 3477 (69%)

Swale 1409 (28%)

Kent 60 (1%)

Others 114 (2%)</td></tr>
<tr><td>Bookings</td><td>Total women booked= 5891

Approx. 91% of all bookings result in birth with MFT continuing care.

9% are pregnancy loss/move out of area.</td></tr>
<tr><td>Case Mix</td><td>This assessment of the case mix, arising from the intrapartum episode, as shown below:

<table><tr><th>Categories I – III</th><th>Categories IV – V</th></tr><tr><td>39.9</td><td>60.1%</td></tr></table></td></tr>
</table>

Movement of Women before and after birth	In 2015 there were 4992 births at Medway Foundation Trust with and 93 (53) planned at home with the rest delivering as an unplanned homebirth or elsewhere. Of the births, approximately 7%, 345 (351) women per annum are transferred postnatally to a neighbouring maternity service and have usually received their community care locally (exports), so this number is deducted from the total births. Approx. 97 (2%) women are seen by the community staff having birthed elsewhere (imports), so this number is added to the annual community cases and totals 5149 (4718).
Antenatal Contacts	Each pregnant woman receives between 7-10 contacts in pregnancy. This totals approx. **32,788 up to 46,840 antenatal appointments (33,026 up to 47,180)**.
Postnatal Contact	Each newly delivered woman receives an average of 3 contacts in the postnatal period. This totals approx. **14,052 (14,154) postnatal visits**.

Kent and Medway Local Overview

The table below shows data on patient flows between CCGs and providers to help understand geographical patterns of service use. Across Kent and Medway women are largely delivering in their local trust with minimal patient flow across geographical boundaries.

The table shows the proportion of admissions for births by CCG to each of the main providers in the LMS footprint. The remaining proportion go to a provider outside of the area.

Caveats – The data is based on number of births in hospital as recorded in the Hospital Episode Statistic (HES) dataset, using the 2015/16 data.

Kent and Medway	East Kent Hospitals University NHS Foundation Trust	Dartford and Gravesham NHS Trust	Medway NHS Foundation Trust	Maidstone and Tunbridge Wells NHS Trust
NHS Ashford CCG	97.8%	0.1%	0.2%	1.0%
NHS Canterbury and Coastal CCG	97.4%	0.2%	0.9%	0.3%
NHS Dartford, Gravesham and Swanley CCG	0.1%	94.7%	1.0%	0.8%
NHS Medway CCG	0.2%	3.1%	94.5%	1.2%
NHS South Kent Coast CCG	99.1%	0.0%	0.1%	0.1%
NHS Swale CCG	2.4%	0.5%	93.5%	2.1%
NHS Thanet CCG	99.1%	0.1%	0.1%	0.0%
NHS West Kent CCG	1.1%	0.6%	1.4%	94.4%

South East Region Overview Chart

From the table, Kent and Medway are performing worse (red) than the national average in the below areas and consequently these priorities will fall into the work streams: under 18 conceptions, teenage mothers, smoking status at time of delivery, caesarean section %, admissions of babies under 14 days, breastfeeding initiation.

Indicator	Period	England	South East region	Bracknell Forest	Brighton and Hove	Buckinghamshire	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhe	Wokingham
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2015/16	29.8	23.6	18.0	17.9	27.7	29.5	14.7	2.8	13.1	13.7	36.0	34.7	28.3	45.0	66.1	21.7	22.4	18.8	28.9	29.1	27.2
General fertility rate	2015	62.5	61.7	61.8	43.7	64.3	58.7	60.9	62.3	62.4	65.2	72.3	59.7	57.9	66.8	79.6	56.3	63.0	62.3	62.9	60.4	61.4
Under 18 conceptions	2015	20.8	17.1	7.4	25.2	11.8	19.3	16.6	17.4	20.6	28.1	20.3	13.2	25.2	22.2	22.2	29.2	11.7	14.6	16.2	9.1	8.1
Under 18s conceptions leading to abortion (%)	2015	51.2	53.7	70.6	61.0	52.6	53.4	52.2	47.5	50.1	48.6	56.4	50.7	48.1	56.4	60.3	43.4	63.7	54.3	59.7	62.5	56.5
Teenage mothers	2015/16	0.9	0.7	-	1.3	0.4	0.9	0.6	1.0	1.0	1.1	0.7	0.5	0.9	0.6	0.4	1.0	0.4	0.9	0.7	-	0.4
Smoking status at time of delivery	2015/16	10.6*	9.7	6.3	6.3	7.4	12.5	9.0	13.0	13.0	16.7	10.9	8.0	12.7	8.0	8.3	14.3	5.8	7.0	8.9	8.6	4.8
Caesarean section %	2015/16	26.3	26.6	25.6	27.2	26.8	26.5	26.3	21.9	27.2	28.5	28.1	20.3	27.6	27.6	27.1	24.9	27.3	28.2	28.5	27.1	27.4
Multiple births	2015	16.0	16.8	22.6	21.0	17.3	14.6	14.8	13.2	18.1	16.5	19.6	17.5	15.9	17.6	12.4	11.9	17.3	17.6	17.3	16.9	15.3
Low birth weight of term babies	2015	2.8	2.3	2.4	2.7	2.8	2.5	2.0	2.6	2.2	2.2	3.0	2.3	2.7	2.6	2.7	2.5	1.9	2.4	2.3	2.3	1.7
Low birth weight of all babies	2015	7.4	6.6	6.8	7.1	7.5	6.0	6.3	7.3	6.3	5.1	7.3	6.2	7.9	6.4	8.2	6.7	6.4	6.4	7.1	6.3	4.6
Very low birth weight of all babies	2015	1.26	1.08	0.88	1.42	1.03	0.90	1.15	1.00	1.05	0.80	1.08	0.89	1.19	0.89	1.08	1.57	1.18	1.20	1.18	0.76	0.71
Stillbirth rate	2013 - 15	4.6	4.3	2.0	4.2	4.8	3.9	3.9	3.1	4.2	5.0	4.4	4.4	3.7	5.9	5.5	4.5	4.4	5.1	3.6	4.2	5.9
Admissions of babies under 14 days	2015/16	66.3	55.4	39.4	39.3	79.4	24.3	61.6	50.3	56.6	87.6	25.3	37.4	75.3	50.0	41.3	58.8	60.7	46.8	52.0	99.6	49.6
Breastfeeding initiation	2014/15	74.3	78.0	82.2	87.9	76.3	76.0	78.8	-	71.3	69.1	-	82.1	74.6	79.0	76.6	73.2	84.7	77.2	81.8	82.4	-
Breastfeeding prevalence at 6-8 weeks after birth - current method	2015/16	43.2*	-	52.4	71.5	-	-	-	47.4	-	-	-	60.2	-	61.3	59.2	-	-	53.9	-	-	60.1
Breastfeeding prevalence at 6-8 weeks after birth - previous method	2014/15	43.8	-	-	72.5	-	-	48.8	45.8	-	-	-	62.6	-	-	-	-	-	-	-	-	-

Source: PHE Fingertips Health Profiles
https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/data#page/0/gid/1938132993/pat/6/par/E12000008/ati/102/are/E06000036

Data from Kent maternity services shows that between 48% and 55% of women are either overweight or obese at booking. Maternal obesity is a major threat to maternal and child health, with links to a number of negative health impacts for mother and baby.

Analysis of data from Kent Integrated Dataset (KID) suggests that service use and costs, both during and after pregnancy, is higher for women and their babies, among women who are obese. It has been estimated that 29% of diabetes in pregnancy, 12% of caesarean section, 5% of post-partum haemorrhage, 4% of preterm delivery, 7% of macrosomia and 5% of admissions to a neonatal intensive care unit or special care baby unit could potentially be avoided if all pregnant women were of normal BMI at the start of the pregnancy (Public Health England, 2015). The same data set also shows that just under two in five pregnant women in Kent have at least one long term condition in which the most common were mental health conditions in 21% and respiratory conditions in 15% of women.

When considering unhealthy lifestyles, data published by Public Health England (PHE) shows that Kent had a significantly higher percentage of mothers smoking at time of delivery than England in 2015/16 and South Kent Coast (16.81%), Swale (20.52%), Medway (17.9%) and Thanet (18.97%) had significantly higher percentages than both Kent and England. The latest figures also show increases in Medway and Swale.

Public Health Outcomes

Increasing Complexity

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in pregnancy and early childhood. The physical and mental wellbeing of the mother, fetal exposures in the womb and early childhood experience have lifelong impacts on many aspects of health and wellbeing (The Marmot Review, 2010) (Wave Trust, 2013).

Smoking in pregnancy is associated with a wide range of problems, including complications during labour, increased risk of stillbirth, miscarriage, premature birth, low birth weight and sudden unexpected death in infancy (NICE, 2010). Smoking, obesity and long term conditions are associated with increased service use during pregnancy and also in the six months following child birth for both mother and baby. Consequently it is associated with increased costs.

It is estimated that 4.5% of women develop gestational diabetes during pregnancy and when considering the potential increase in population, these issues will need to be taken into consideration when looking at service capacity to ensure that services can cope with the increase in women with long term conditions, mental health problems, smokers and those who are obese.

Approximately half of all women of childbearing age in England are either overweight or obese. Although data on maternal BMI is not routinely collected, results from a large national study conducted in 2007 found that 15.6% of pregnant women had a BMI of more than 30. In total 10% had a BMI of 30-34.9, 3.8% had a BMI of 35-39.9, 1.6% had a BMI of 40-49.9 and 0.2% had a BMI of 50 or more. Studies have also shown an increase in the prevalence of obesity over time. (Public Health England, 2015)

Women who are obese (BMI of 30 or more) when they become pregnant have an increased risk of complications in pregnancy and childbirth (NICE, 2010), which includes induced or longer labour, instrumental delivery, caesarean section or postpartum haemorrhage. Reduced mobility in labour can lead to an increased need for pain relief, which can be difficult to administer in obese women, meaning an increased need for general anaesthesia with its associated risks. Obese women are more likely to spend longer in hospital because of problems during pregnancy or delivery related to their weight.

Babies born to obese women also face a number of health risks. These include an increased risk of fetal death, stillbirth, congenital abnormalities, shoulder dystocia and macrosomia. They are also at increased risk of obesity in the future.

The table below shows the result of this increased uptake of smoking cessation services in terms of number of cases due to smoking that could be avoided and the total cost of these cases. This demonstrates that even a comparatively small increase in the number of women receiving stop smoking support of 160 women (translating to an additional 84 quitters) could result in a total of 28 maternal and infant complications avoided, and savings of £53,084.

Table 10: NICE modelling, savings from maternal and infant complications avoided.

	Local assumptions		
Details	**Cases due to smoking[1]**	**Unit cost £[2]**	**Total cost £**
Maternal complications			
Ectopic pregnancy	1.15	1,081	1,243
Premature rupture of membrane	9.46	2,679	25,343
Placenta praevia	0.89	2,679	2,384
Abruption placenta	0.48	2,679	1,286
Pre-term delivery	5.55	2,679	14,868
Pre-eclampsia	- 0.65	2,679	- 1,741
Total maternal complications	**16.88**		**43,384**
Infant complications			
Low birth weight	6.62	870	5,759
Respiratory distress	2.81	870	2,445
Sudden infant death syndrome (SIDS)	1.72	870	1,496
Total infant complications	**11.15**		**9,701**
Total savings	**28.03**		**53,084**

[1] Number of cases that would be expected to be avoided if uptake of smoking cessation services increased as in the previous table.
[2] Based on 2010/11 national tariff costs
Source: NICE

Teenage Mothers

Teenage pregnancy often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and wellbeing and the likelihood of both the parent and child living in long term poverty.

Teenage mothers are three times more likely to smoke during their pregnancy, are 50% less likely to breastfeed, and babies born to teenage mothers are at an increased risk of prematurity, congenital abnormality, low birth weight and death during infancy. Infant mortality in this group is 41% higher than that of babies of older women and children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.

We know that most teenage pregnancies are unplanned and many – just under 50% in 2013 – end in abortion, which represents and emotional cost to the parent and an avoidable cost to the NHS.

Reducing under 18 conceptions has been a longstanding national and local priority for both health and local authority children and young people's services. A substantial reduction in the teenage conception rate has been achieved in recent years: the under 18 conception rate in 2015 was 21.0 conceptions per thousand women aged 15 to 17; this is the lowest rate recorded since comparable statistics were first produced in 1969.

Medway's teenage conception rate has also fallen but has remained consistently above the South East average and significantly above the England average since 2010. The rate of teenage conception in Medway was 28.1 per 1,000 women aged 15 – 17 in 2015.

Teenage Conceptions 2011-2015:

Year	2015		2014		2013		2012		2011	
Area of usual residence	Number of Conceptions	Conception rate per 1,000 women in age group	Number of Conceptions	Conception rate per 1,000 women in age group	Number of Conceptions	Conception rate per 1,000 women in age group	Number of Conceptions	Conception rate per 1,000 women in age group	Number of Conceptions	Conception rate per 1,000 women in age group
ENGLAND	**19,080**	**20.8**	**21,282**	**22.8**	**22,830**	**24.3**	**26,157**	**27.7**	**29,166**	**30.7**
SOUTH EAST	**2,627**	**17.1**	**2,929**	**18.8**	**3,184**	**20.5**	**3,617**	**23.2**	**4,087**	**26.1**
Medway	**140**	**28.1**	**170**	**33.2**	**171**	**33.4**	**175**	**33.6**	**206**	**38.8**
Kent	**573**	**20.6**	**631**	**22.2**	**649**	**22.9**	**725**	**25.9**	**871**	**31.0**

Taken from ONS:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/datasets/quarterlyconceptionstowomenagedunder18englandandwales)

Across Kent in 2015, 1.10% of mothers were aged under 18 years, varying across CCGs, from 0.70% in West Kent CCG to 1.93% in South Kent Coast CCG. South Kent CCG had a rate significantly higher than Kent. EKHUFT (1.5%) and Medway (1.3%) Trusts have higher proportions of births to mothers aged under 18. None of the trusts are significantly different to Kent mothers as a whole.
In 2015, there were 23 births with a mother aged under 16, accounting for 0.13% of births. The percentage of births to mothers aged under 16 varied according to CCG, from 0.0% in Ashford, to 0.36% (6 births) in Thanet. No babies from Kent mothers aged under 16 were born in trusts outside Kent, while in EKHUFT, 0.2% of births were to mothers aged under 16. None of the CCGs or trusts had a percentage that was significantly different to that of Kent.

The percentage of mothers aged under 20 in 2015 across Kent was 4.04%, ranging from 2.88% in Ashford CCG to 5.85% in South Kent Coast CCG. South Kent Coast, Swale (5.72%) and Thanet (5.82%) CCGs all had significantly higher percentages than Kent, while West Kent CCG (3.06%) had a significantly lower percentage. EKHUFT (4.9%) and Medway (5.8%) trusts have a significantly higher proportion of births to mothers aged under 20, while MTW (3.1%) has a significantly lower percentage.

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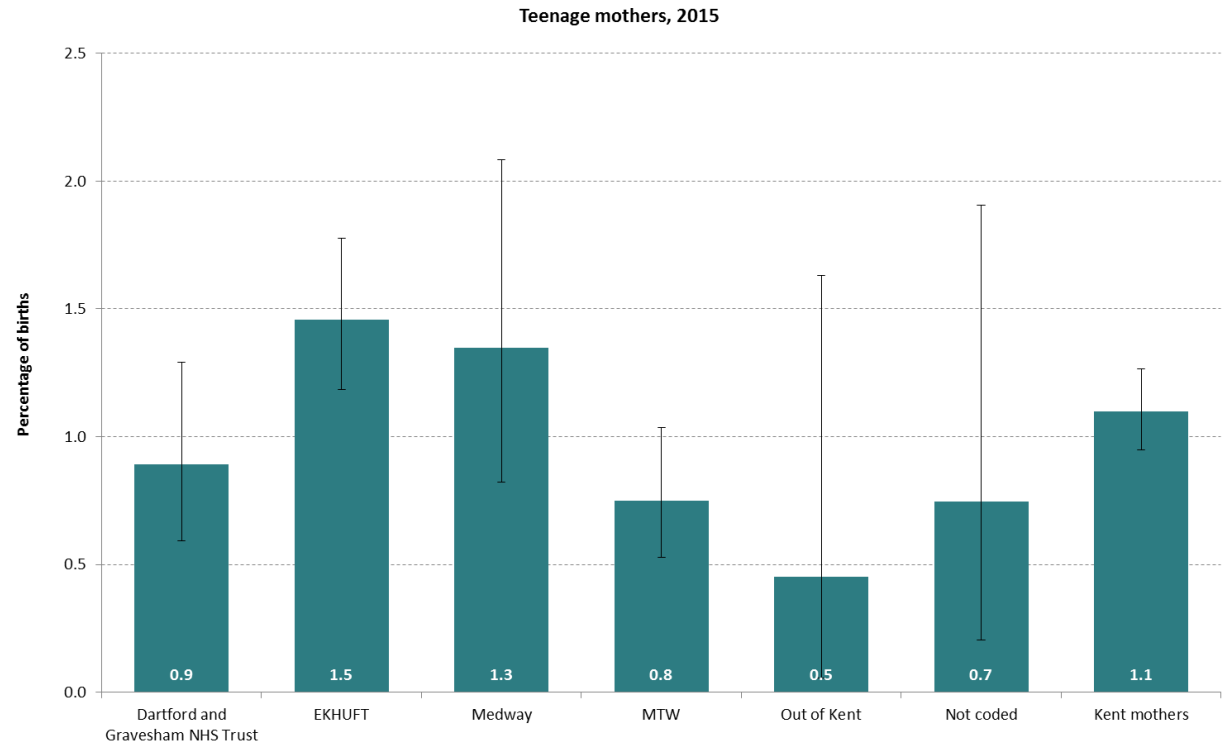


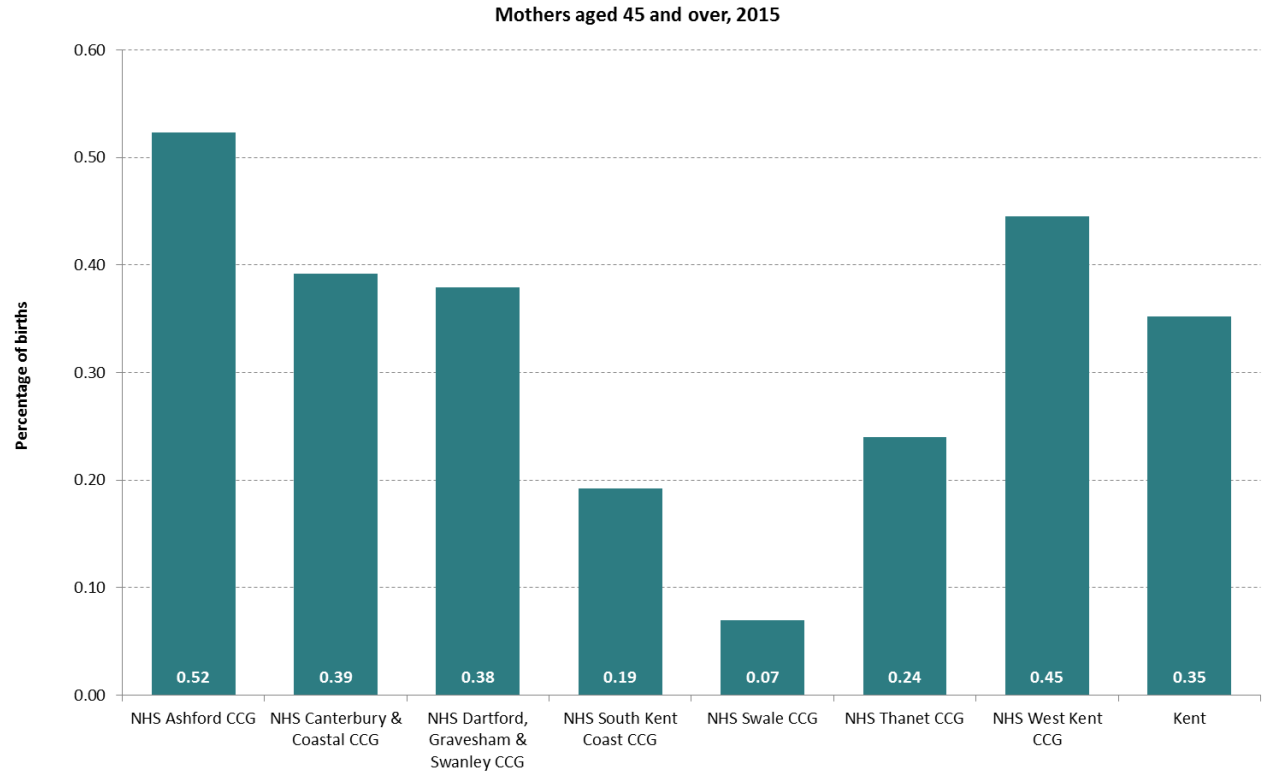
Source: PHBF, prepared by KPHO (ES), 11/16

Mothers Aged 40 and Above

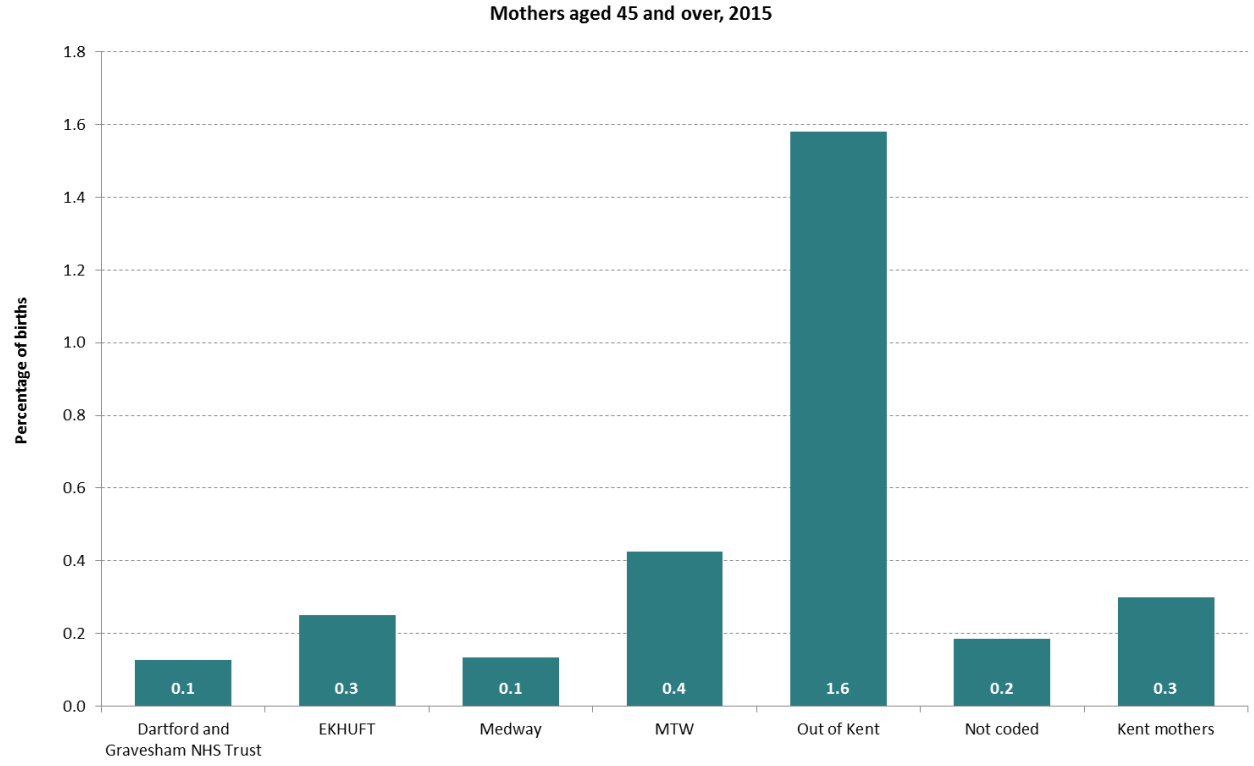
The risks of childbirth to women >35 year or above is associated with increased risk of adverse maternal perinatal outcomes, such as postpartum haemorrhage and eclampsia, with increased risk of adverse outcomes to the infant including preterm birth, poor fetal growth, low birth weight and neonatal mortality.

Across Kent, 4.06% of mothers were aged 40 and above. This percentage was highest in West Kent CCG (5.03%), significantly higher than the Kent figure. Swale CCG had the lowest proportion of mothers aged 40 and above, at 2.58%, and along with Thanet (2.70%) was significantly lower than Kent. MTW (5.0%) and trusts outside of Kent (8.4%) have a significantly higher proportion of mothers aged 40 and above.

In 2015, there were 61 births with a mother aged 45 and above, accounting for 0.35% of births. The percentage of births to mothers aged 45 and above varied according to CCG, from 0.07% in Swale CCG (<5 births, number suppressed), to 0.45% (24 births) in West Kent CCG. None of the CCGs had a percentage that was significantly different to that of Kent. The percentage of babies born to mothers aged 45 and above is substantially higher in trusts outside of Kent (1.6%); however, this is not significantly different to all Kent mothers.



Source: PHBF, prepared by KPHO (ES), 11/16



Source: PHBF, prepared by KPHO (ES), 11/16

Smoking in Pregnancy

Smoking in pregnancy is associated with a wide range of problems, including complications during labour, increased risk of stillbirth, miscarriage, premature birth, low birthweight and sudden unexpected death in infancy. It also increases the risk of infant mortality by 40%. Longer term, it is associated with an increase in wheezy illnesses during childhood and psychological problems such as attention and hyperactivity problems.

The national ambition for smoking in pregnancy is 6% at delivery. Kent and Medway have a high percentage of women smoking in pregnancy and this challenge has been recognised at a national level with Thanet, South Kent Coast, Medway and Swale CCGs being awarded additional funding of £75,000 from NHSE to support maternal smoking cessation.

CCG Area	% of pregnant women smoking (at time of funding allocation)
Thanet	21%
South Kent Coast	17.5%
Medway	17.5%
Swale	24%

CCGs have worked very closely with Public Health Colleagues in Kent and Medway in order to plan for and allocate this funding. Interventions include the following:

- Additional training for Midwives to support building skills around having the challenging conversation with women.
- Stop Smoking advisors offering home visits.
- Reinforcement of the Babyclear pathway
- Purchase of CO monitors and consumables
- Resources for Midwives
- Expansion of the 'What the Bump' campaign in Swale and Medway
- Health Visitor training

Smoking cessation is a prevention priority for the Kent and Medway STP. This includes driving forwards the Smoke Free Hospitals agenda and support and encouragement for maternal smokers to quit.

Obesity

Approximately half of all women of childbearing age in England are either overweight or obese. Although data on maternal BMI is not routinely collected, results from a large national study conducted in 2007 found that 15.6% of pregnant women have a BMI of more than 30. In total, 10% had a BMI of 30-34.9, 3.8% had a BMI of 35-39.9, 1.6% had a BMI of 40-49.9 and 0.2% had a BMI of 50 or more. Studies have also shown an increase in the prevalence of obesity over time (Public Health England, 2015). Women who are obese (BMI of 30 or more) have increased risks of complications in pregnancy and childbirth (NICE 2010). Risks include impaired glucose tolerance and gestational diabetes, miscarriage, pre-eclampsia and maternal death.

High maternal BMI is associated with increased health service usage and costs (Public Health England, 2015) and NICE guidance (2010) recommends that women with a BMI of 30 or more who may become pregnant should be supported to lose weight before becoming pregnant.

There is an increasing challenge concerning obesity. All NHS Trusts in Kent and Medway are attempting to address this but currently, interventions are different. Maidstone and Tunbridge Wells NHS Trust have employed two healthy weight midwives who run healthy weight clinics for women with a raised BMI of over 35.

It is planned that the Kent and Medway LMS will measure, share, learn from and implement good practice from the NHS Trusts within its footprint. It will also be important to consider the role of Public Health and the preparation for pregnancy by losing weight prior to conception.

It is planned that good practice and learning concerning the management of obesity (both at the pre-conception and during pregnancy stages) will be applied throughout Kent and Medway with the LMS leading the co-ordination of this.

Mental Health

The Kent and Medway Mother and Infant Mental Health Service (MIMHS) provided by Kent and Medway Partnership Trust (KMPT) have been successful in gaining funding of £2.3 million from the Perinatal Mental Health Community Services Development Fund. This will be used to expand the current team, enabling an additional 598 women per annum to access the specialist perinatal mental health service close to home. Care will be more comprehensive, integrated and seamless in line with NICE Guidance (CG192) and The Royal College of Psychiatrists standards (CR197). Key benefits will include:

- Direct access for all referrals (current routed through generic community mental health teams).
- Comprehensive multidisciplinary assessment and treatment.
- Increased outreach and integrated care within settings close to home such as children's centres, community hubs and obstetric clinics.
- Increased access to psychological therapies.
- Provision of specialist occupational therapy interventions to support parenting skills.
- Provision of groups to enable peer support (in response to service user requests).
- Enhanced capacity to offer specialist training to other professionals to improve early detection and intervention across the perinatal mental health pathway.

NHS England has confirmed that KMPT has been successful with its bid to provide a new mother and baby mental health inpatient unit in the South East for patients from across Kent, Surrey and Sussex. The expansion in mother and baby unit capacity is part of NHS England's work programme to improve the access and quality of perinatal mental health services across the country.

KMPT's existing Mother and Infant Mental Health Service (MIMHS) already provides an excellent community service to mothers across Kent and Medway who need mental health advice and treatment during pregnancy and up to one year after birth. Previously, when admission to a specialist inpatient unit was needed, new mums could face being placed outside in a unit up to 200 miles away from loved ones. Or, if no specialist beds were available to accommodate them with their new born baby, mother and child would have to be separated.

The new specialist unit, which will be based in Kent, will mean that women from across Kent, Surrey and Sussex who experience mental ill health during pregnancy, or in the year after birth, and require specialist input, will be able to get the support and care they need while also continuing to be with their baby.

Whilst this additional funding and expansion of specialist perinatal mental health services will be beneficial for women across Kent, there remains a challenge in relation to perinatal mental health. It is often reported that those women with 'moderate level' perinatal mental health needs are poorly served by current services. This will be considered by the LMS as a part of the plan of work, to enable effective perinatal mental health services to be provided to all women in the future.

Breastfeeding Initiation

NICE have developed guidance on maternal and child nutrition (NICE, 2014), which includes guidance aimed at improving rates of breastfeeding. Kent and Medway are both outliers for breastfeeding initiation (South East Region Overview Chart).

The LMS is committed to working closely with Public Health colleagues to support the Kent integrated infant feeding pathway (including Medway), BFI Status for all Trusts and the growth of breastfeeding initiation.

Trusts Current BFI Status

Trust	**Current BFI Status**	**Breast Feeding Initiation** (average 16/17)
Dartford and Gravesham NHS Trust	Level 2, working towards level 3 (hoped to be achieved by Dec 17)	68.1%
East Kent Hospitals University Foundation Trust	No BFI Status at present	69.4%
Maidstone and Tunbridge Wells NHS Trust	Working towards Level 2	
Medway NHS Foundation Trust	Level 2 status, working towards level 3	69.6%

Birth Weight

Low birth weight is classified as a baby born weighing less than 2,500g. Babies born weighing less than 1,500g are categorised as very low birth weight. This is expressed as a percentage of all live births.

Low birth weight is a major predictor of infant mortality and of adverse health outcomes in childhood and adulthood. Two thirds of all infant deaths in England and Wales are among those born with low birth weight. Babies just below the 2,500 grams threshold for low birth weight are five times as likely to die as an infant born with normal birth weight, whilst babies born with extremely low birth weight (less than 1,000g) are 200 times more likely to die than those born with a normal birth weight.

Low birth weight is associated with poor outcomes in child health, and in particular cognitive skills. In addition, low birth weight is also associated with health problems in adulthood such as diabetes, stroke and lung disease, and other long term health difficulties including defects in growth and cognitive development.

There is a well-established socio-economic gradient for low birth weight. Rates of low birth weight are higher in groups of higher socio-economic disadvantage and are associated in particular with negative health behaviours which are more common in these groups such as poor uptake of antenatal care, smoking, poor nutrition during pregnancy and substance misuse.

Across Kent, the percentage of babies born with a low birth weight (premature and at term) has reduced slightly, from 6.2% in 2006/08 to 5.8% in 2013/15. All CCGs within Kent show a decreasing or plateauing percentage of low birth weight babies, with the exception of Dartford, Gravesham and Swanley which has increased since 2008/10. Over the next three time periods, the percentages are expected to continue to decline, particularly for Swale, Ashford and Thanet CCGs.

A substantially higher proportion of low birth weight babies are born in non-Kent trusts, and this percentage is increasing, rising from 10.1% in 2006/08 to 14.8% in 2013/15. The three main trusts in Kent have fairly stable percentages of low birth weight babies.

In 2014, 2.7% of all live births 'at term' (a gestational age of at least 37 weeks) with recorded birth weight in Medway were born with low birth weight. This is similar to the England average of 2.9%.

Based on pooled data for 2013-2015, 5.8% of babies born in Kent weighed less than 2,500g. Across the CCGs, this ranged from 4.5% in Swale CCG to 6.7% in Thanet CCG. The percentage of babies born weighing less than 2,500g is significantly lower in Swale CCG (this needs further investigation to establish whether it is a reflection of recording error or true difference in low birth weight); none of the CCGs have a significantly higher percentage in comparison with Kent. By trust, there were no significant differences in the proportion of babies born weighing under 2,500g between the main Kent trusts. The proportion born with a LBW in trusts outside Kent was significantly higher than the total, at 14.8%. The proportion born in trusts outside of Kent was significantly higher than the total, at 5.1%.

Case Mix Data

Average case mix data by Kent and Medway NHS trust 16/17 and national assumptions, based on the definitions contained within n the guidance for the national maternity tariff, the maternity pathway payment system:

			Average	National Assumptions
ANTENATAL:	**Intensive**	**EKUHFT**	9.70%	11.30%
		DVH	12%	
		MTW	11%	
		MFT	13.25%	
	Intermediate	**EKUHFT**	32.60%	38.70%
		DVH	36%	
		MTW	31%	
		MFT	44.83%	
	Standard	**EKUHFT**	57.70%	50.00%
		DVH	53%	
		MTW	59%	
		MFT	41.93%	
POSTNATAL:	**Intensive**	**EKUHFT**	0.50%	0.67%
		DVH	0%	
		MTW	0%	
		MFT	0.29%	
	Intermediate	**EKUHFT**	20.30%	22.01%
		DVH	24%	
		MTW	19%	
		MFT	35.85%	
	Standard	**EKUHFT**	79.20%	77.32%
		DVH	76%	
		MTW	73%	
		MFT	63.84%	

Risk and Safety Management

Unit Closures

NHS Trust	Closures in Last 3 Years
East Kent Hospitals University Foundation Trust	One closure on 17.7.15 for 6 hours due to capacity on both LWs
Dartford and Gravesham NHS Trust	One closure- Nov 14- bed capacity
Maidstone and Tunbridge Wells NHS Trust	4 hour closure- summer 2015
Medway NHS Foundation Trust	2014-2015 = 2 2015-2016 = 12 2016-2017 =5

Closures are underpinned by a system of patient transfer across trusts in Kent and Medway (and beyond if necessary), to ensure continued access to maternity services.

Still Births

Table 5: the number of still births by CCG (2010 to 2015) CCG	2010	2011	2012	2013	2014	2015
NHS Ashford CCG	8	5	13	*	8	8
NHS Canterbury & Coastal CCG	14	7	*	8	8	7
NHS Dartford, Gravesham & Swanley CCG	21	24	14	14	18	21
NHS South Kent Coast CCG	15	12	9	9	6	6
NHS Swale CCG	13	9	6	*	5	5
NHS Thanet CCG	9	6	*	9	8	6
NHS West Kent CCG	27	29	14	17	18	24
NHS Medway CCG						
Kent	107	92	65	64	71	77
*Numbers <5 suppressed	Source: PHBF, prepared by: KPHO (LLY), 09/16					

Caesarean Section and Admissions

The South east region overview chart relating to health profiles from the PHE fingertips data, shows that compared to the England average of 26.3% for 15/16 caesarean section, Kent and Medway are performing worse at 27.2% and 28.5% respectively. In the same period, Medway performed significantly worse than the England average when looking at admissions of babies under 14 days also at 87.6 per 1,000 compared 66.3 per 1,000. Kent performed better in this time frame with 56.6 per 1,000.

More recent data from the 4 Kent and Medway trusts shows the below for caesarean sections and admissions of babies under 14 days:

EKHUFT C/S 28.9%

MFT C/S 28.01%

DVH C/S 29%

MTW C/S

Serious Incidents and Maternal Deaths

Across K&M when looking at data for 16/17 across the 4 trusts there were a cumulative total of 42 serious incidents relating to maternity services. In the same time period there were also 4 maternal deaths.

Neonatal Deaths-trajectories and timescales

The MBRRACE-UK report focuses on rates of stillbirth and neonatal death across the UK for babies born at 24 weeks of gestation or more. There continues to be a statistically significant decrease in the maternal death rate in the UK, however, there has been no significant change in the rate of indirect maternal death over the last 10 years.

- **DVH- have benchmarked themselves against national measures in which it was noted there is reasonable quality assurance against MBRACCE. An action plan has been introduced with changes in practice such as the re-introduction of annual still birth report, audit of GROW programme, better communication with GPs,**
- **EKHUFT-**
- **MTW-**
- **MFT- compliant against MBRRACE, currently reviewing and updating the epilepsy in pregnancy guidelines.**

Issues, Risks, Challenges and Opportunities

Issues	Risks	Challenges	Opportunities
Just under 2 in 5 pregnant women in Kent have at least one long term condition.	Lack of STP support	IT systems to link across K&M- E3	Training of midwives to undertake to sonography- widen skills (Medway FT)
Population increase = increased birth rate	Workforce capacity in some areas of the system- i.e. sonographers- gap and grow increased demand	K&M wide agreement from labs to share scan/blood results to ensure women can cross geographical boundaries.	Improving standards across K&M and making approaches to care consistent.
Midwifery workforce – high proportion nearing retirement.	Reduced WTE of more experienced bandings. Losing experienced midwives who are able to support new graduates and returners to the profession	Recruitment and retention of midwifery workforce.	Looking at flexible working options across the footprint in order to retain knowledge and skills within the wider workforce.
Increase in clinical complexity of pregnancy due to LTC and increasing issues such as smoking and obesity.	Lack of funding to support LMS	Capacity and demand increase across K&M	Improved linkages with additional services that are available, and solidifying joint working processes across Kent and Medway.
Currently fragmented pathways and variation between trusts.	Fragmented pathways and clinical variation	Medicalised models of care	The LMS looking at maternity services systematically across K&M with 'fresh eyes' will allow greater scope for unified working across the patch
Changing attitudes of all trusts and commissioners to think as single system.	Potential propensity for silo thinking, given rising demand and increasing pressure	Variations in CQC ratings as a barrier to joint working	Opportunities to share good practice and potential to develop areas of regional specialism

Alignment with Local Networks

Complex System, Geographical Area

LMS's will be able to access coordinated support from NHS England and other system partners. A bespoke support package will be devised in partnership with the K&M LMS and provided through the South East Maternity Clinical Network, regional maternity boards and the national programme team working together.

Maternity Clinical Networks will work in close partnership with Local Maternity Systems and be their primary source of support. Clinical Networks will provide clinical input and expertise, supporting Local Maternity Systems to establish themselves, and draw up and implement local maternity transformation plans. They will help Local Maternity Systems understand and interpret national policy for local implementation. They will support benchmarking of the quality of services and spread good practice from across the country. They will bring in different parts of the system as appropriate to support individual Local Maternity Systems and resolve particular local issues and challenges.

South East Clinical Networks support delivery of the core clinical programmes within the Five Year Forward View by connecting commissioners, providers, professionals, patients and the public across pathways of care with the aim of improving health outcomes. This is achieved by sharing best practice and innovation, assessing and benchmarking quality and outcomes and driving improvement where required through targeted support.

Complementary Neonatal Operational Delivery Networks will also be able to help Local Maternity Systems deliver and ensure services are seamless, providing high quality care to mother and babies.

The South East Neonatal Operational Delivery Network (SEODN) is hosted by Medway NHS Foundation Trust. The SEODN will support the Kent and Medway LMS co-develop an overarching regional strategy to deliver improvements in the following areas:

- Optimisation of birth place for premature infants to support the national ambition.
- Reduction in term admissions (ATAIN programme).
- Workforce planning

The SEODN works with commissioners and acute providers; there is consistent reporting in place as required for the NHSE E08/S/a service specification for Neonatal Care Services.

The SEODN Manager is a member of the Maternity Clinical Network Steering Group and Clinical Advisory Group; they are starting to work on the National Maternity Review recommendations. There is a National Neonatal Service Review just starting, led by NHSE with input from the Neonatal Networks. The SEC Neonatal Network is keen to work with the STP's and Local Maternity Systems to ensure alignment with services.

There are good systems in place between fetal medicine and the neonatal units to ensure safe plans for birth and immediate care required by the new-born immediately after birth. Systems or the network includes input from the following groups / sources:

- **South East Clinical Networks Commissioning Forum- support**
- **Perinatal Mental Health**
- **Kent and Medway Antenatal and New-born Screening Board**
- **Regional team**
- **HoMs**
- **Maternity Safety Forum**
- **Cancer**
- **Linking in with Public Health e.g. The Healthy Child Programme**

Kent and Medway LMS Approach

The K&M LMS will be working to improve quality for women and their families through a new whole systems approach to maternity services. This will primarily be focused on pathway development, which consequently will reduce variation, identify gaps in services and provide seamless pathways via the single point of access. The model represents a significant shift in the way that current maternity services are provided, to ensure the recommendations of Better Births are implemented and for maternity services in K&M to work as a single system.

The LMS will be developing a Local Maternity Offer, setting out clearly the full range of services available across the LMS and how to access them. This includes targeted services for women who need additional support such as mental health services and help to manage their health during pregnancy. The offer will be available online and in a range of other formats.

Pathways and links with other services

Maternity services need to have effective and efficient links with all services to ensure better outcomes for women, children and their families. A priority for Kent and Medway will be clear referral pathways for high risk pregnancies to ensure care is high quality, locally accessible, driven by patient outcomes and cost effective.

This will include:

- Health improvement services
- Pre conception initiatives
- Early Help services such as Children's centres
- Health visitors
- GPs
- Neonatal services
- Maternal and Fetal medicine services
- NHSE specialise services

Communications and Engagement

K&M LMS will develop a communications and engagement strategy by the end of March 2018 to involve all stakeholders including women and their families, GPs, midwives and other health professionals.

- The Kent and Medway wide Maternity system will develop a multi-faceted approach to co-production of maternity services in the area in order to ensure that health inequalities are addressed, that all members of society are empowered to make decision about their maternity care and ensure that services are equally accessible.
- Service user groups, such as the MSLC groups that already exist in all areas will be involved in supporting the design and delivery of maternity services in line with the recommendations. Currently some of the MSLC groups are not as proactively involved in maternity services as others. These will be re energised, as members can offer very useful skills and knowledge which will help develop the services for the future and are to be replaced by Maternity Voices Partnerships (MVPs).
- Discussions have already started to re-launch the Medway& Swale and Dartford Gravesend & Swanley MSLC as a single North Kent Maternity Services Liaison Committee. East Kent is also encouraging more active participation. The MSLC group at Maidstone and Tunbridge Wells, known locally as Birth Voices has provided a lot of useful input in literature for women, design of the birth centres as well as undertaking surveys of women's views about parent craft.
- User engagement tools such as 'Whose Shoes', which has been used at Maidstone can be used to gain further information about users opinions as well as the use of social media such as Twitter and Facebook.

- Providers and commissioners will proactively explore additional options for service user involvement, looking at social capital and network links already in place that can be used as a foundation for building further engagement. A communication and engagement plan will be developed to support the implementation of the delivery plan with clear objectives and timelines for engagement. This will ensure that all the members of our communities have the opportunity to become involved in maternity services developments.
- The communication and engagement plan will be subject to an Equality Assessment which will ensure that all members of our communities have the opportunity to be involved in the development of maternity services regardless of any existing protected characteristics. It is anticipated that bringing together experiences from across Kent will enable commissioners and services providers to continue to share good practice in relation to achieving positive outcomes for all members of local communities
- The communication element of the plan will be key to ensuring that communication developed by commissioners and providers are accessible to everyone, to enable informed choices and decisions about maternity care to be made. This will include the production of accessible 'easy read' materials which is particularly relevant to mothers/partners with learning disabilities and for members of the community for whom English is not their first language
- WHAM has also undertaken engagement with women towards all elements of the pioneer work including development of the choice booklet, feedback on community hubs approach and towards other resources used.

Commissioning

K&M LMS will be moving towards a standard approach to outcome focused commissioning in order to develop key performance indicators, improve outcomes for women and commission across boundaries.

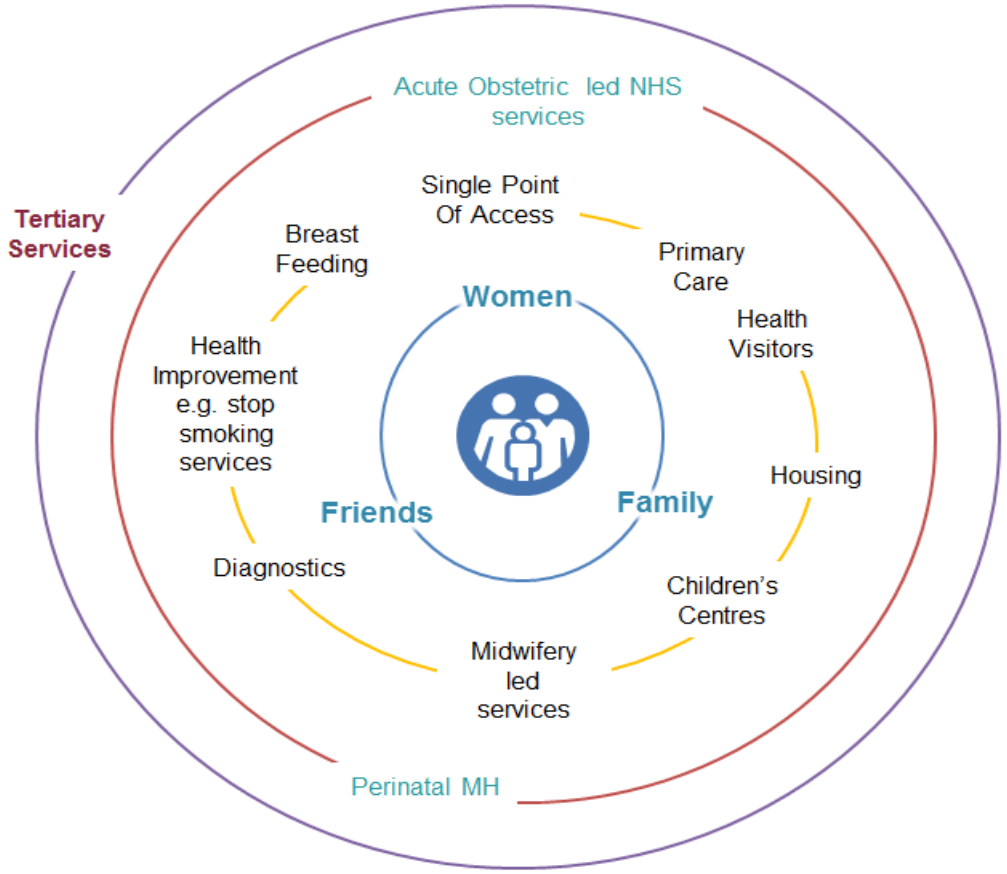
We will commission and deliver the right care, at the right place at the right time and ensure outcomes are met by developing a K&M dashboard.

Continuity of Carer

Kent and Medway Local Maternity System Operating Model

Our aspiration for Kent and Medway Local Maternity System is to have a model of care which promotes a family friendly, kind, professional, personalised and safe service.

- Choice and Personalisation
- Perinatal Mental Health
- MVP
- Continuity of Carer
- Safety and Quality
- Improving Health
- Education and Training
- Data, Information and Finances
- Workforce Planning



Governance

National Governance

The National Maternity Transformation Board is responsible for co-ordinating action nationally in line with the recommendations set out in Better Births. They are supported by the national programme team who link with the regional boards in supporting and assuring delivery. It is planned that the national programme team will attend regional boards and provide evidence and lessons learned from other regional areas where required.

Regional Boards are responsible for overseeing and supporting the local delivery by Local Maternity Systems. The regional board will have the responsibility for assurance of both the development and implementation of the LMS Transformation Plan. There will be a lead nominated in each region to Chair the board and resources to support its operation.

Maternity Clinical Networks will work in close partnership with the Local Maternity System and be their main support. Clinical Networks will offer clinical input, support with benchmarking the quality of services, assist in the understanding and interpretation of national policy.

The Local Maternity System will also seek advice and support from appropriate clinical networks such as the Neonatal Operational Delivery Network and the Perinatal Mental Health Clinical Network. These interfaces will support the Local Maternity System to plan for safe and best practice leading to the delivery of seamless high quality care.

LMS Governance

The K&M LMS will be a formal subgroup of the STP with which it is co-terminus. The work of the LMS will be overseen and agreed by the STP strategic partnership board. The membership of the LMS will work alongside the identified STP enablers ensuring that priorities are shared. The LMS will be further linked into the STP by senior leadership which will be connected into the governance of the STP.

The Kent and Medway Local Maternity System will establish a strategic partnership board with terms of reference in order to make decisions.

At present, there are 4 different NHS Provider organisations for maternity in Kent and Medway. These organisations will need to align with each other in order to offer safe and seamless care for women and babies and to break down the boundaries between them at a number of levels. Developing shared clinical governance will be a challenge but is not insurmountable.

It is anticipated that the governance arrangements for the K&M LMS will evolve over time. However, the Kent and Medway LMS will establish governance around the following priorities:

- **Safety:** The LMS will use the work completed within its Safety and Quality work stream in order to set out how shared learning and related training will take place across the system. This will build on the existing assurance mechanisms in place across providers such as the Kent and Medway Patient Safety Forum, a multi-agency meeting with representatives from the Ambulance Service, Health Visitors, GP's and Perinatal Mental

Health. It will also give the opportunity for clinicians of all levels to learn from each other across the LMS area.

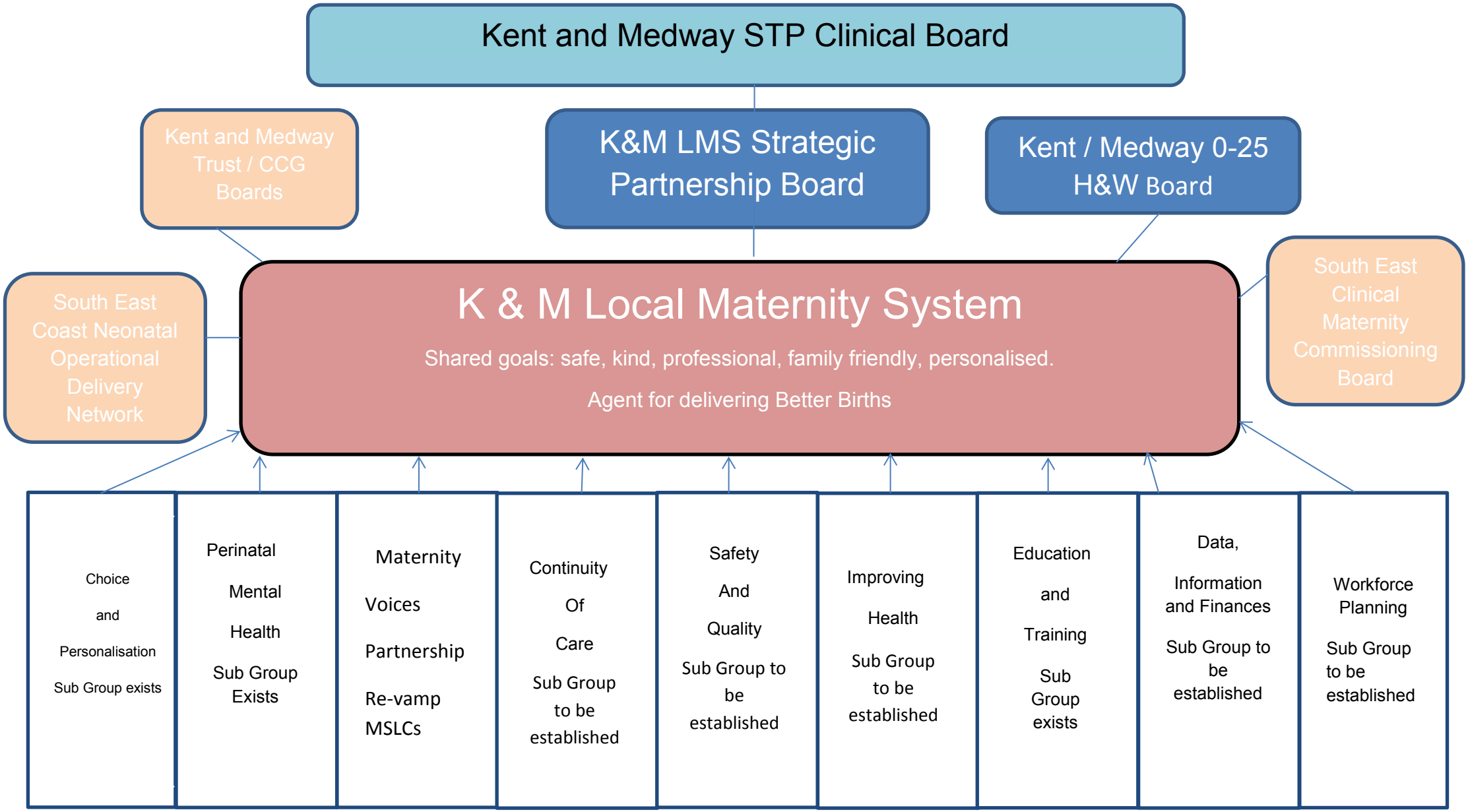
- **Shared standards and guidelines:** These will ensure that the clinical teams across the LMS area will be working to shared definitions of care.
- **Pathways:** All maternity providers will have knowledge of the shared pathways across the LMS. These pathways will also cover the interdependencies with other services, such as fetal medicine, neo-natal services and perinatal mental health.
- **Referral and transfer protocols:** The LMS will establish consistent referral and transfer protocols. We will consider the benefits of a single point of access for women and look at how this could be established in an accessible manner. We will ensure that there is clarity around receiving services from a range of maternity providers across Kent and Medway and also from those interdependent with maternity services. This will be collated into the LMS Local Offer, which will be easily available for all women and their families.
- **Record Keeping:** The LMS will link in with the digital enabler of the STP in order to investigate ways in which medical records can be digitalised and shared across organisations.
- **Data:** There will be a systematic and regular review of data. This will involve the establishing of a Kent and Medway Service Specification, Key Performance Indicators and a localised dashboard which will incorporate patient experience feedback. This will be used to support monitoring of safety, quality and service improvement across the LMS. This data can also be used to measure the progress towards implementing the recommendations in Better Births. All Kent and Medway trusts will be expected to flow maternity datasets into the (KID) which will support robust evaluation and modelling, whilst linking to data from other services.

Where appropriate a Memorandum of Understanding (MoU) will be established between NHS organisations so there is clarity around the sharing of clinical guidance, standards and guidelines. The LMS will be instrumental in creating the MoU.

The LMS will develop a collaborative approach to maternity commissioning. Commissioners across Kent and Medway will work together to investigate the tools which can be used to allow for the sharing of a single service specification. There will be shared process for the monitoring of quality and performance within the maternity contract and the Service Development and Improvement Plan (SDIP) could be used to focus on specific and dedicated project work leading to improvements in safety and quality.

All decisions made will be based on NICE Guidance, the evidence available, standards of professional bodies (such as RCOG and RCM) and best practice. This will be supported by the learning established in the pioneer for personalisation in West Kent and the regional Early Adopters.

Governance Structure



K&M LMS Work Streams

The work streams will consist of staff from all bandings across all organisations (provider and commissioner) and will be led by the following:

Choice and Personalisation- WHAM

Perinatal Mental Health- KMPT

Maternity Voices Partnership- Service Users

Continuity of Carer- Community Midwives (all bands)

Safety and Quality- Labour Ward Leads / Quality Leads

Improving Health- Public Health

Education and Training- HoMs with input from midwives

Data, Information and Finance- IT/Data Leads, Contracts and Finance

Workforce Planning- HoMs and Higher Education Institutions

Considerations for all work streams:

- Safety
- Deprivation of women and families
- Age profile of women to include teenage mothers
- Smoking in pregnancy
- Obesity
- Long term conditions
- Immunisations

The LMS will be required to agree the membership of work streams (above) and identify relevant reporting streams back into the LMS governance structure. These work streams will also be added to throughout the transformation work as current capacity does not allow the K&M LMS to prioritise all areas at once.

The work streams will also include links to pathways and aim to strengthen support women receive from the system, particularly looking at safeguarding and protecting vulnerable women and children from domestic abuse.

Project plan reporting template will be completed by each work stream and fed into LMS (risks, issues, milestones etc).

Recommendations for K&M STP / NHSE

	Recommendation	Rationale	Action
Kent and Medway STP	The LMS is formally recognised as a subgroup of the STP.	The LMS needs to align with the work of the STP.	The LMS will be formally recognised within the governance of the STP and a representative allocated.
	The LMS is represented in the appropriate STP work streams.	NHSE have recommended that the LMS is the maternity element of the STP	LMS will be represented in the STP work streams and be included in relevant work plans.
	Support the LMS to appoint Clinical chair / rolling chair- Clinical Director.	Enable time out of clinics / schedules to support the LMS programme in order to ensure effective implementation.	STP to agree and inform LMS of outcome
	Maternity through the LMS to be represented on the STP clinical board	Link in with above.	Recognised role for the clinical chair of the LMS when appointed on the STP clinical board.
	That the LMS is linked with the STP digital transformation work strand.	Kent and Medway Maternity services need to be linked digitally in order to achieve the ambition of shared data and information across the footprint.	STP to establish formal links with the LMS as part of their digital transformation work strand.
NHSE	Ensure RCOG is on board with the maternity transformations and understands what this means locally / supports clinicians locally.	Obstetricians need to understand the wider maternity transformation and understand that it isn't just about midwifery services.	Communicate and work with RCOG.

Choice and Personalisation Pioneer

With a Choice and Personalisation Pioneer in K&M, the learnings will be shared nationally and rolled out across the entire area. There is a focus on:

- Improving choice by implementing private midwifery organisation in locality
- Piloting a Personal Maternity Care Budget in order to offer women choice at all stages throughout the pathway
- Providing women with unbiased information in order to let them make informed choices
- Thorough engagement with women to ensure the project is based on what they want

The choice and personalisation pioneer WHAM is currently piloting a personal maternity choice package for women offered within two community midwifery teams. At the end of Aug 2017, 692 women had accepted a personal maternity choice package and to be a part of the pilot. This is primarily focused on ensuring women are aware of all of their choices throughout the maternity pathway, which includes breaking down geographical boundaries and offering out of area trusts for women to deliver in.

The resource which was developed and co-designed with women, is being evaluated before wider roll out across the pioneer site and has also been reviewed by the Kent and Medway LMS. With this in mind the resource will be implemented across the K&M LMS footprint for all women to use and have access to unbiased information in order for them to have a more personalised birth and exercise more choice. This will be in use across the LMS by the end of March 2019 with the view of it being available online also.

As part of this work also, WHAM is looking at the feasibility of piloting the implementation of private midwifery organisations on small scale initially, in which the learning can then be disseminated across the LMS for larger scale contracts.

It is widely recognised that the maternity pathway tariff is incredibly restrictive to choice for women in which as a result of this, WHAM has developed a Personal Maternity Care Budget, breaking down the maternity pathway payment into unbundled costs to allow women choice of providers at different elements of the maternity pathway. This will be piloted and the learning from this will be shared with the LMS.

Core Business.

All trusts in Kent and Medway LMS have benchmarked themselves against the recommendations set out in Better Births. This has consequently allowed the LMS to identify to priority areas and to look at both the short term and long term ambitions. This will be updated yearly in order to measure progress.

Maternity Benchmarking- LMS A

All trusts will also undertake a variation analysis to understand differences in services.

	Short Term Priorities	**Long Term Priorities**
Safety and Quality	Maternity Safety Forum already exists in which all HoMs from K&M attend. Twice yearly - SIs from all trusts are shared and reviewed in the meeting in order to learn. - This process will be formalised with an action plan / learning log from each SI review meeting so it is on record and monitored. Link in with the safety cycle and ownership over actions fed back into the trusts. Learning from NHSI Safety Collaborative: - **Phase 1:** East Kent Hospital University Foundation Trust - **Phase 2:** Maidstone and Tunbridge Wells NHS Trust Medway NHS Foundation Trust - **Phase 3:** Dartford and Gravesham NHS Trust	In November 2015, the Secretary of State for Health announced an ambition to reduce the rate of stillbirths and neonatal and maternal deaths in England by 50% by 2030, as well as to target the number of brain injuries occurring during or soon after birth. It was supported by a national package of measures and funding, which included: • An £8 million maternity safety training fund to support services to drive improvements in maternity safety. • The launch of the 'Our Chance' campaign, targeted towards pregnant women and their families to raise awareness of the symptoms that can lead to stillbirth. • A £250,000 maternity safety innovation fund to support local maternity services to create and pilot new ideas. • The Maternity and Neonatal Health Safety Collaborative, to help services identify and implement quality improvement. Establish Clinical Operational Committee A priority for Kent and Medway will be clear referral pathways for high risk pregnancies into Fetal Medicine Services. This will include but is not limited too, clearly defined pathways for Chronic Villus Sampling (CVS), fetal abnormalities

	Undertake scoping exercise to understand all trusts current approach and information in relation to safety collaborative work as a baseline to show progress going forwards. Learning from EKHUFT 'in house' BESTT initiative Engagement in the Improvement Maternity and Neonatal Quality Improvement Programme. Develop K&M model of care using other areas examples i.e. BUMP.	and fetal cardiology scans across K&M.
Improving Health	Sub-group to be established Pre-conceptual care initiative and strategy to focus on preparation and key health messages related to pregnancy. Health Prevention / Health promotion strategy to be developed by end of March 2018 to include short and long term priorities focusing on the benefits and cost savings. This will link with: PH outcomes framework http://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy **Smoking**: Specialist Midwives (across Kent and Medway) for smoking cessation to form a task and finish group focussing on creating a Kent and Medway approach. This will incorporate learning from the innovative projects piloted with the recent NHSE additional funding to support maternal smoking cessation. This will include:	Pre-conceptual care strategy in place to support women in getting fit for pregnancy and increasing awareness of key health messages such as smoking and breastfeeding. Ambition to roll this out in a number of settings including education, children's centres and public areas such as supermarkets, shopping centres and workplaces. Prevention Strategy- standardised across K&M • During pregnancy • After pregnancy • Health and wellbeing / lifestyle • Antenatal classes / parent education • Preventative health in infants related to health visitor and GP interventions. Improving vaccination coverage, smoking, child development, breastfeeding support, psychological interventions, identifying behavioural change and weight measures in children. • Heathy weight • Diabetes • Work with GPs on pre conception messages **Smoking-** reduce smoking in pregnancy rates and smoking at time of delivery by strengthening smoking cessation and midwifery links resources and develop

	- Universal CO monitoring at booking and also at other opportune points - Increasing referrals to stop smoking services and evaluation of home visit option piloted in Thanet, South Kent Coast and Swale. - Looking for innovative approaches to motivate staff compliance and for training - Smoke Free Hospitals **Infant Feeding**- map pathways, identify gaps/overlap in services. -design K&M wide template **Parent Education**- K&M wide programme Uptake of screening and immunisations including flu jab during pregnancy and pertussis. Look at benchmarking services against national antenatal and new-born screening programmes to ensure compliance and develop action plans if required. **WHAM**- developing pre-conceptual care strategy to support women in getting fit for pregnancy and increasing awareness of key health messages such as smoking and breastfeeding. Ambition to roll this out in a number of settings including education, children's centres and public areas such as supermarkets, shopping centres and workplaces. Ensure links to the troubled families agenda and work streams, including support for	whole systems approach. **Infant Feeding**-increase breastfeeding initiation rates & breast feeding continuation at 6-8 weeks by promoting Unicef's Baby Friendly Accreditation and implement Infant Feeding Action Plan. Health risks associated with long term conditions, mental health, smokers and obese women need to be appropriately managed during pregnancy and in the post-partum period. Complete benchmarking of services against national screening programmes and develop action plans as necessary.

	hard to reach communities.	
Maternity Voices Partnership	Develop K&M approach to MVPs Support on engagement with women across Kent and Medway to inform / gain views on LMS developments.	MVP integrated, co-producing and supporting design, implementation and review of Maternity services.
Data and Information	Review maternity data flows between trusts and how data is being used. Trusts to allow access and sharing of Maternity data/dashboards and their diagnostics. The creation and implementation of a communications strategy for all stakeholders. Develop action plan around data processing for trusts to flow maternity data into the KID in order to enable modelling and robust evaluation of any proposals.	The creation of a Kent and Medway dashboard to be used to monitor quality and performance outcomes. Standardised maternity record across Kent and Medway.
Finance	The LMS to allocate NHSE funding for financial year 2017-2018 to the following (£76,666): - The appointment of a Clinical Chair (Obstetrician). - The appointment of a Project Manager. - The appointment of admin support. - The creation of a K&M Maternity Voices Partnership (using NEL CSU and the North Kent CCG engagement team to support a focus group model). - K&M LMS 'branding'.	The creation of a Kent and Medway single point of access (SPA). Implementation of labour line across K&M. Clinical Chair for the LMS established and backfill in post. Learning from the Pioneer to implement a revised financial system across Kent and Medway to support Choice. By doing things differently across the whole K&M health system there will be savings long term. These will become more apparent as the work is implemented across the LMS footprint and services are aligned with the local offer.

IT/Digital	Pioneer will investigate the possibility of a website to support the Kent and Medway Local Offer. Scoping exercise to be completed focusing on all IT systems across all NHS Trusts and primary care and community care services e.g. Health Visiting. Gather scoping information concerning IT/Digital pilots taking place across England such as; the e-red book, Family Assist.	Kent and Medway electronic notes system where maternity notes and information can be accessed at point of care. This includes service users, primary care and other services such as Health Visiting, Mental Health Services. There will be a Kent and Medway wide App which will include elements such as advice, links to local services, the Local Maternity Offer, tracking of pregnancy. The creation of a Kent and Medway Single Point of Access (SPA). Build on the Pioneer website
Communication and Engagement	Commissioners to engage actively with all stakeholders (women and their families, health professionals, GPs etc) and maternity staff in their CCG areas concerning Better Births and future plans of the LMS. Trust midwives at all bandings to be involved in LMS work stream and task and finish groups. Other health professionals including health visitors to be integrated into the work streams. Consider joint (across Trust) training opportunities. The establishment of a task and finish group around continuative care and how it can be implemented for the most vulnerable groups in Kent and Medway.	Continuative care model to be driven by all midwives in both acute and community teams.

Kent and Medway LMS Delivery Plan

The purpose of the delivery plan is to align the recommendations / actions to each of the work streams so there is a clear allocation of priorities. This will form the basis of the work streams individual project plans and give clear timescales for completion of work. It will allow the LMS to monitor progress and measure outcomes regularly and ensure the transformation is on track throughout.
The comments in red are 'I statements' from service users to reflect their ambitions for 2021.

Recommendation / Action	Owner and *Work Stream*	Timeframe and Priorities	Measurement and Outcomes	Ambition for 2021
1.1 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.	Providers and CCGs ***Choice and Personalisation*** ***Improving Heath***	End of March 2018 Choice and Personalisation Pioneer in West Kent. **Short term:** K&M to offer standard personalised care plan (based on WHAM template) by end of March 2019 which will include mental health, health improvement and long term conditions information **Long term:** K&M standard care plan to be available online by end of March 2020	Maternity survey and e-referral data. Develop local offer. 100% of women offered personal care plan to include mental health, health improvement and long term conditions.	*I feel that my midwife and other health care professionals care about me and can fully support me.* *I feel that the relevant information is easily accessible to the providers of my care and me. I appreciate having electronic access to my personalised care plan.* *I will have digital access to my records including my previous notes.* *I will have the opportunity to add comments and additions to my notes and personalised care plan. This will include my current and previous pregnancies*

1.2 Unbiased information should be made 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.	National Information Board (NIB) and NHS England ***Data, Information and Finances*** ***Improving Health***	By April 2017 **Short term:** Agree consistent information to all trust websites to ensure women receiving standard messages across K&M by end of March 2018 which includes pre-conception messages. - All trusts to review contents of leaflets currently provided antenatally and postnatally Improving health to develop pre conception messages for K&M Flow maternity data into KID Trusts submit data to the LMS annually for peer review / benchmarking **Long term:** Single Point of Access across K&M implemented by 2021 K&M LMS website	Maternity survey and NIB Monitoring. Pioneer booklet will be implemented across K&M Implemented Single Point of Access.	*I feel confident that the information given to me will be up to date and based on the latest evidence and NICE guidelines.* *Information is easily accessible digitally.* *I will be seen as an individual and the information is appropriate to my personal circumstances.*
1.3 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	NHS England and CCGs ***Choice and Personalisation***	**Short term:** WHAM currently undertaking pilot which will be rolled out across whole pioneer patch bye end of March 2018 to ensure women are informed of all choices. Pioneer pilot WHAM is looking to pilot a Personal Maternity Care Budget in which	Maternity survey, e-referral data and CCG Assessment. Pioneer PMCB- learning will be shared across K&M	*I feel confident that I have a choice of care provider through my whole pregnancy, birth and postnatally.* *I understand that I don't need to worry about making any direct*

Personal Maternity Care Budget		learning will be shared with K&M LMS 17/18. Baseline review to look at current service provision across K&M and identify gaps by end of March 2018. WHAM to pilot implementation of private midwives. All trusts to agree read only E3 by all K&M trusts. **Long term:** K&M roll out PMCB based on WHAM approach once finance systems and payment systems are reconfigured.		*payments.* *I have the opportunity to attend the antenatal education classes of my choice within my care budget.*
1.4 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	CCGs ***Choice and Personalisation***	**Short term:** By March 2019 K&M will be using Pioneer choice booklet. **Long term:** SPA will enable women to make unbiased informed choices. Midwifery training to ensure midwives are working as LMS not as silo trusts- changing attitudes.	Maternity survey, e-referral data and CCG Assessment	*I feel supported in my choices and my care provider.*
2.1 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	Providers and CCGs ***Continuity of Carer***	**Short term:** Establish work stream sub group. Trusts to undertake workforce review / capacity planning.	Maternity survey. All trusts will be working to same model.	*I have developed a positive relationship with my midwives; I feel that I am supported and that we have a mutual understanding.* *I feel I have been looked after well during my pregnancy, birth and*

pregnancy, birth and postnatally	***Workforce Planning***	**Long term**: K&M to develop model by end of March 2019 which will include post-natal care. Implement K&M model by end of March 2021.		*postnatally by my team of midwives.* *I feel that my choices have been heard and respected.* *Because of our antenatal journey together, I am familiar with the Midwife who is attending my baby's birth.*
2.2 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	Providers and CCGs ***Continuity of Carer*** ***Workforce Planning***	**Short term:** Trusts to undertake workforce review / capacity planning by end of March 2019. **Long term:** All midwifery teams to work alongside named obstetrician.	Staff feedback Work force planning and consistent approach across K&M.	*I feel confident that my care providers work as part of a team and are happy and well supported in their jobs.*
2.3 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	NHS England – national support and guidance; CCGs and providers – local implementation ***Choice and Personalisation*** ***Improving health***	**Short term:** WHAM Pioneer exploring Community Hubs and to agree model by end March 2018. Identify opportunities with STP to link in with local care work and community hubs that are being developed. **Long term:** Implement standard approach to community hubs across K&M by end of March 2020.	CCG Assessment	*I have easy access to care locally and as a result I am familiar with my care providers.*

2.4 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	Providers ***Continuity of Carer*** ***Improving health*** ***Workforce Planning***	K&M to work on local model- focus on certain cohort of women i.e. vulnerable women, high risk for the continuity of carer model- those that need it and where it will have the most impact rather than all women	Maternity survey, Local Maternity System governance	*I am confident that the maternity care service is well organised and that I have care near home.*
3.1 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	Providers	By 1 April 2016/17 **Complete**	CQC inspections	
3.2 Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training. CQC should consider these issues during	Providers and CQC ***Education and Training***	From 2016/17 Education and Training sub group in place. **Short term:** Staff understanding of maternity transformation programme. Staff understanding and increased knowledge of other services.	CQC inspections	

inspections		Human Factors training across K&M. Make Every Contact Count training across K&M. All trusts to nominate champion to develop parent education classes across K&M. All trusts to ensure Safeguarding Adults training undertaken and K&M approach developed. **Long term:** Multi-professional training across K&M- shared learning. Consistent approach to parent education across K&M provided by a number of health professionals.		
3.3 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	Providers and CCG ***Safety and Quality***	Full roll out by end of March 2020 **Short term:** Sub group to be established with representation from all trusts. All referral protocols to be reviewed and standard referrals developed across K&M. K&M wide escalation plan (to take into account capacity issues) linking in with SECAMB. Link in with Maternity Safety Forum - Maternity Patient Safety Forum to become the membership of this subgroup - Linking with EKHUFT in first round of	Local maternity system governance	

		NHSI safety Collaborative for lessons learned. Incorporate into LMS planning. - Monitor progress on Still Birth care Bundle across Kent and Medway. - Shared learning and good practice learning across K&M - K&M service specification - K&M wide approach to midwifery supervision - K & M screening, immunisation and referral pathway. All trusts to implement Saving babies Lives **Long term:** Implement standard referral pathways across all trusts by end of March 2020 (link in with SPA by end of 2021).		
3.4 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	Providers and regional networks ***Safety and Quality*** ***Improving Health***	**Short term:** By end of March 2019 K&M agree quality outcomes for all trusts. Agreed approach to A-EQUIP model of Midwifery supervision across K&M by end of March 2018. **Long term:** All trusts submitting data against agreed outcomes by end of March 2020. Implement agreed approach to A-QUIP model of Midwifery supervision by end of March 2019. Improving health outcomes are effectively	Regional clinical network monitoring, CQC inspections. Performance monitoring. Benchmarking data.	

		collected such as smoking at time of delivery etc.		
3.5 There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.	Health Care Safety Investigation Branch, NHS Improvement, Maternity Clinical Networks	By end 2016/17 Adhere to national standardised process for investigating serious incidents within national screening programmes.	DH / NHS Improvement / HCSIB monitoring.	*I understand that there is a clear and immediate response to the problems that happened during the birth and with my care.*
3.6 There is already an expectation of openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly.	DH and NHS Litigation Authority	By 2020 All trusts to work within Rapid Resolution / Redress scheme by end of March 2018.	DH implementation Work within rapid redress/ resolution scheme	
4.1 There should be significant investment in perinatal mental health services in the community and in specialist care	Mental Health Implementation Board, NHS England and CCGs ***Perinatal Mental Health***	By 2020 **Short term:** Mother and Baby Unit in Dartford by end of March 2018 Head of Service for Mother and Infant Mental Health Service (MIMHS) part of LMS. **Long term:** Reduce perinatal infant mortality rates	CCG Assessment Framework, Mental Health Minimum Dataset (MHMDS), MCMDS	

		Review all pathways to implement standard K&M protocols.		
4.2 Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby	CCGs and providers ***Continuity of carer***	This will be built into Continuity of Carer model and implemented by end of March 2021.	Maternity survey, MCMDS	*I feel confident that I am supported through the early days of parenthood. This will include access to my midwife in order to 'check in' informally to make sure that baby and I are both doing well.* *My midwife knows me and shows me care and compassion when I need it most.* *Because I have honest communication with my midwife she will help me and give me information for my mental health and wellbeing.* *My midwife will signpost me to other services which will be useful and also where I can meet other new mums.* *I will receive appropriate and correct evidence based information from professionals who will recognise and value my breastfeeding goals.*
4.3 Maternity services should ensure smooth transition between midwife and obstetric and neonatal care, and	CCGs and providers ***Safety and***	By end of March 2018 **Short term:** Review and develop standard pathways (including those for screening and	Maternity survey Review of pathways/referral protocols	

when appropriate to ongoing care in the community from their GP and health visitor	***Quality*** ***Improving Health***	immunisations, fetal medicine), clinical governance, protocols and process across K&M. Sharing of information across all pathways; maternity, health visitors, FNP. **Long term:** Implement standard pathways, clinical governance, protocols and process across K&M be end of March 2021 (link in with SPA).		
5.2 Multi-professional training should be a standard part of professionals' continuous professional development, both in routine situations and in emergencies.	NHS England, HEE, RCM, RCOG, Employers ***Education and Training***	DH and HEE fund post registration training in 2016/17 Thereafter responsibility of employers- **Long term:** Implement multidisciplinary training across K&M by end of March 2021	HEE reporting CQC inspection Board reporting	
5.3 Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software, equipment and	NHS England, providers ***Data, Information and Finances***	By 2020 **Short term:** All NHS Trusts in Kent and Medway will understand and agree how they will share data and information between professionals, organisations and with the woman. **Long term:** Implement electronic maternity records across K&M by 2020. Reform maternity payment system by end of	Digital Maturity Self-Assessment will cover electronic records generally	

infrastructure to collect data and share information		March 2021- money follows the women. Reform the maternity payment system- to include screening, lab monitoring, avoid duplication, date sharing, K&M agreement		
5.5 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.	RCOG and RCM to provide support, employers to release professionals ***Education and Training***	By end 2017/18 **Short term:** **Long term:**	RCM and RCOG reporting CQC Inspection	
6.1 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	NHS England – national support and guidance; CCGs and providers – local implementation	Planning for working in this way 2016/17 begin to work in this way from 2017/18. Full roll out by end 2020	CCG Assessment	
6.2 Professionals, providers and commissioners should come together on a larger geographical area through Clinical	NHS England national and regional funding and support; CCGs and providers are	From now **Short term:** K&M LMS established with recommended membership. Attendance at Clinical Networks and	NHS England assurance of Clinical Networks	

Networks, coterminous for both maternity and neonatal services, to share information, best practice and learning, to provide support and to advise about the commissioning of specialist services which support local maternity systems	members ***Data, Information and Finances*** ***Improving health***	feedback fed into LMS. K&M Immunisation and Screening networks established. **Long term:** K&M local agreement from all labs to share data to avoid duplication and waste. • maternity and lab IT processes that support screening and immunisations pathways		
6.3 Commissioners should take greater responsibility for improving outcomes, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly	CCGs ***Safety and Quality***	From now – with demonstrable progress by end 2020/21 Commission against clear K&M outcomes to improve services which includes public health.	CCG Assessment	

Immediate Actions

1. Use NHSE funding to recruit project support
2. Establish all work streams
3. Trusts to undertake variation analysis
4. Memorandum of Understanding to be signed off
5. IT scoping exercise
6. Staff engagement across K&M

SUMMARY / CLOSING STATEMENT

The K&M LMS are a group of inspirational and motivated professionals, stakeholders and service users working together as a collaborative to make women's lives better through the transformation and the implementation of safe, personalised, professional and high quality maternity services. We are the agent for the delivery of Better Births, in line with the Five Year Forward View and we will provide the planning and leadership for the transformation of Maternity services throughout our STP footprint.

Delivering the Better Births vision is reliant upon a wide range of organisations and stakeholders working together and embracing change to ensure high quality services for women, babies and their families. The purpose of the K&M LMS is to provide place based planning and leadership for this transformation. The Kent and Medway LMS Transformation Plan details how the recommendations contained within Better Births will be achieved locally. This is set out in the 'Core Business' and the 'Kent and Medway LMS Delivery Plan' sections.

The K&M LMS will work closely with service users and their families in order to ensure that co-production is at the heart of what we do. As a LMS, we will develop a local vision for improved maternity services and outcomes in an open forum, to enable suggestions and insight from all members. This will help shape the local transformation in a robust and transparent way."

The K&M LMS transformation plan has been agreed by the STP and also by the Kent 0-25 Health and Wellbeing Board and Medway Health and Wellbeing Board. This agreement will allow the K&M LMS to move ahead in implementing the delivery of the recommendations contained within Better Births.

Appendix

K&M MoU v1.doc

Supporting Documents

http://www.kpho.org.uk/__data/assets/pdf_file/0005/68513/Maternity-NA-2017-compressed.pdf

http://www.kpho.org.uk/__data/assets/pdf_file/0005/43358/ReviewrelationshipPublicHealthMaternityKent-01_12_14.pdf

http://www.kpho.org.uk/__data/assets/pdf_file/0009/57960/Perinatal-Mental-Health-Needs-Assessment.pdf

http://www.medwayjsna.info/jsna-appendices-adults.html

Implementing *Better Births:*
Integrating Neonatal Care into Local Maternity System Transformation Plans

References:

(KCC, 2017) Maternity Needs Assessment. March 2017. Kent Public Health Observatory

(Public Health England, 2015) Prevalence

http://webarchive.nationalarchives.gov.uk/20170110171101/https://www.noo.org.uk/NOO_about_obesity/maternal_obesity_2015/prevalence

Wave Trust 2013

State of Maternity Services RCM 2016

https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf