Thames Valley
Strategic Clinical Network

Thames Valley SCN Triangulation Document

PURPOSE:

- The intention of this document is to enable discussion and establish a shared vision and plan for the STPs specific to TVSCN and its Local Maternity systems in order to implement recommendations from 'Better Births' which is being delivered through NHS England's' National Maternity Transformation programme.

- This triangulation process aims to synthesize the 2 strategic reports in 2016 which were written as a result of Capacity issues in Thames Valley for Maternity services: *TVSCN Maternity Capacity and Future Planning Report, June 2016 and the subsequent TV Clinical Senate Maternity Forum Report, November 2016;* .and then align to recommendations from the National Maternity review 'Better Births' also published in 2016 in order to prioritise and agree an action plan for the LMS for each STP. 4 Key priority areas highlighted were:
    - Capacity – Including Choice
    - Safer Care
    - Finance
    - Workforce

- The detail behind this short report can be found in the reports referenced

- The Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of organisations to lead and deliver across 9 work streams and are considered throughout.

1. Capacity

The Case for Change (TVSCN Maternity Capacity and Future Planning Report, June 2016)

All Trusts are able to provide the appropriate level of maternity services to women currently. However, not all Trusts are able to offer the 4 choices of place of birth although from a Thames Valley SCN Maternity perspective these are available across the region. Currently there are times of peak activity when some maternity units have to divert women to other providers, close their MLU or not offer a home birth due to staffing. Therefore considering the capacity and capability of Maternity services over the next 10 years is an important issue.

Capacity is potentially required for an additional 2870 births across Thames Valley SCN .The increase of projected births in Oxfordshire is 8%, Berkshire East 18% and Berkshire West 17% over the next 10 years. The Buckinghamshire county council and Milton Keynes Council have predicted a 3% increase in number of births between 2016 and 2025 and between 2016 and 2026 respectively. This capacity includes the entire maternity pathway which the SCN recommends is from preconception to post-natal care provision.

Recommendations

TOPIC:				
Capacity & Provision: Impact on Choice	TVSCN	TV Senate	Better Births	NHS E : Personalisation and Choice Work stream
	5. Women and their families to be included in maternity planning so they are truly engaged and understand the	4.1 Maternity services should be commissioned as a whole pathway and antenatal services should be delivered as close to home as possible and start as early as possible in pregnancy to	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 Personal Maternity Care Budget.	https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-pioneers/ Online NHS E maternity choices survey

	complexities of service planning and delivery.	empower women to make appropriate choices for themselves.	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 after full discussion of the benefits and risks associated with each option.	for women underway
	10. Trusts and Commissioners to work together to agree and fund the additional capacity required to care for women throughout the maternity pathway; preconception to the end of the postnatal period.	4.7 There was a sense, from each of the perspectives, that some level of local solution is required to address the local capacity issues but that this would not be feasible without the provision of capital monies. All providers said that this would be problematic and that it should be considered on Thames Valley wide basis. 4.10 One of the issues raised concerned consistency of service so that women and/or staff moving between different provider services could feel confident that the pathways and protocols would be the same. This should be addressed within the collaborative working arrangement.	1. Personalised care centred on the woman her baby and her family based around their needs and their decisions where they have genuine choice informed by unbiased information	

Alongside Midwifery led Units (AMUs)	7. Where Trusts in the TV can increase their beds in their AMU they should do so where possible to be able to manage additional requests from women to birth in the unit with the additional workforce and the appropriate infrastructure necessary to deliver this service.	4.5 It was agreed that AMUs are perceived to be a good choice from the perspectives of both women and staff and that increasing the number would be an effective way of increasing capacity providing building space and finance was available.		
Freestanding Midwifery led Units (FMUs)	12. Commissioners who do not provide or commission an FMU to explore the feasibility options in their local areas in order to manage requests from women to birth in such a unit.	4.3 The FMUs have very low activity rates and it was suggested that more work is undertaken to understand the cause for this. Currently it is not clear whether the low numbers are a result of how the choice is communicated to women. 4.4 Currently, given the low levels of activity, there was no support to increase the numbers of FMUs. More work is required to identify the services which FMUs support and facilitate to understand the		

		whole scale and cost of these units.		
	8. Each Maternity provider to consider how their FMUs are staffed using evidence from other providers for example the OUHFT model.			
Home Births	9. Review of home birth provision and the introduction of labour assessments at home. The impact of increasing home births on the FMUs must be considered as both may not be viable. The National Maternity review highlights examples of models where women birthing at home are supported by a midwife and a maternity support worker; this should be working towards a 3% home birth rate as provided by FHFT, WPH, and MK.	4.6 Home births have a low level of uptake and it was suggested that work is also undertaken to understand the cause for this. It is not clear whether women make an informed choice not to give birth at home, whether low numbers are a result of how the choice is communicated to women or how often the option is withdrawn due to staff shortages. It would be helpful to know in order to plan future services. 4.13 The collaborative arrangement offers the opportunity to establish a shared team for home births (dependent on the findings of the review of women's choices regarding home births).		

Collaborative Model	18. The TVSCN Heads of Midwifery and Lead Obstetrician expert group work together to understand the potential impact of decision making by one Trust on neighbouring organisations which needs greater clarity and collaboration			
	19. The TVSCN Heads of Midwifery and Lead Obstetrician expert group to consider the impact of capping numbers of bookings.			

2. Safer Care

The Case for Change (TVSCN Maternity Capacity and Future Planning Report, June 2016)

As well as capacity requirements, the capability of the maternity service also must be considered. The Thames Valley Maternity SCN believes services have the capability to work collaboratively to provide consistent care to women and their babies. This work is underway following the establishment of the Maternity Network at the Oxford ASHN and the Thames Valley Maternity SCN and good progress is being made in a number of projects.

Recommendations

TOPIC:	**Safer Care**			
Safer Care	TVSCN	TV Senate	Better Births	NHS E : Safer Care and Data work stream NHS I : National Maternity and Neonatal Safety Collaborative
	6. The TVSCN recommends that the entire pathway for women is commissioned to include preconception counselling so women are risk assessed appropriately and cared for by the appropriate	4.10 One of the issues raised concerned consistency of service so that women and / or staff moving between different provider services could feel that the pathways and protocols would be the same. This should be addressed within the collaborative working	3. Safer care, with professional working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong. 3.1 Provider organisation boards	

	teams.	arrangement.	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. 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 inspections. 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. 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.	

			3.6 There is already an expectation of openness and honesty between professional 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.	
	14. The care of high risk women should be correctly funded and commissioners and providers from across TVSCN should agree funding streams and commission the correct number of obstetric and high dependency beds in the relevant units.	4.12 It was agreed that another opportunity for the collaborative would be to identify whether there would be value in individual providers developing an excellence in a particular element of maternity service.	3. Safer care, with professional working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.	https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/
Monitoring	Thames Valley SCN does not currently have a dashboard but there is agreement from the Strategic Heads of Midwifery and Lead Obstetrician group to develop a dashboard with support from the Oxford AHSN Maternity		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.	

	Network. The purpose of the dashboard is to monitor and support maternity services as well identifying and sharing areas of good practice. Agreement is required about which forums will discuss the dashboard and a process for monitoring trends and actions.			

3. Finance

The Case for Change (TVSCN Maternity Capacity and Future Planning Report, June 2016)

The role of the existing payment structure is to reimburse providers for the cost of the care they provide. The financial situation is impacting on the provision of maternity services across the region and the changes to the tariff system, Payment by Results means that all maternity services are deemed to be unaffordable or not cost effective. This is especially relevant for Trust's providing specialist services such as fetal medicine where there is no tariff to provide this time consuming and specialist service.

Commissioners commission their local Trust to provide a range of maternity services, however, due to geographical locations of units some women will not give birth in their local maternity unit. This impacts on Trusts as women will choose to have all or part of their maternity care in a different Trust. This is becoming more of a financial issue as Trusts need to ensure they receive the tariff for the care provided to women. Unless this is resolved it may affect where women can have their antenatal and intrapartum care. It is also a potential safety issue as results of investigations may not be available or have to be repeated when a woman is admitted for labour care**.**

Recommendations

TOPIC:	**FINANCE**			
	TVSCN	TV Senate	Better Births	NHS E : Pricing and Personalisation and choice work streams
Choice / Capacity / Commissioning	10. Trusts and Commissioners should work together to agree and fund the additional capacity required to care for women throughout the maternity pathway;	4.7 There was a sense, from each of the perspectives, that some level of local solution is required to address the local capacity issues but that this would not be feasible without the provision of capital monies. All providers said that this would be problematic and that	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 Personal Maternity Care Budget. 7. A payment system that fairly and adequately compensates providers for	https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-pioneers/questions-and-answers-about-maternity-pioneers/pmcb-funding/

	preconception to the end of the postnatal period.	it should be considered on Thames Valley wide basis. 4.8 There is a concern about the tariff and the impact of exceeding 6,000 births. Whilst the costs of going over 6,000 can be calculated, it is not known at what point the costs become break even and some modelling and/or benchmarking should be undertaken to understand this in more detail to enable robust planning and to inform further discussions.	delivering high quality care to all woman, whilst supporting commissioners to commission for personalisation, safety and choice. 7.1 The payment system for maternity services should be reformed. In particular, it should take into account: • The different cost structures different services have, i.e., a large proportion of the costs of obstetric units are fixed because they need to be available 24 hours a day, seven days a week regardless of the volume of services they provide. • The need to ensure that the money follows the woman and her baby as far as possible, so as to ensure women's choices drive the flow of money, whilst supporting organisations to work together. • The need to incentivise the delivery of high quality and efficient care for all women, regardless of where they live or their health needs. • The challenges of providing sustainable services in certain remote and rural areas. 4.1 There should be significant	

			investment in perinatal mental health services in the community and in specialist care. 4.2 Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby.	
	12. Commissioners who do not provide or commission an FMU to explore the feasibility options in their local areas in order to manage requests from women to birth in such a unit.	4.4 Currently, given the low levels of activity, there was no support to increase the numbers of FMUs. More work is required to identify the services which FMUs support and facilitate to understand the whole scale and cost of these units. 4.5 It was agreed that AMUs are perceived to be a good choice from the perspectives of both women and staff and that increasing the number would be an effective way of increasing capacity providing building space and finance was available. 4.6 Home births have a low level of uptake and it was suggested that work is also undertaken to understand the	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 Personal Maternity Care Budget.	

		cause for this. It is not clear whether women make an informed choice not to give birth at home, whether low numbers are a result of how the choice is communicated to women or how often the option is withdrawn due to staff shortages. It would be helpful to know in order to plan future services.		
High Risk Women	14. TVSCN recommends that the care of high risk women is correctly funded and that commissioners and providers from across Thames Valley SCN agree funding streams and commission the correct number of obstetric and high dependency beds in the relevant units.			

4. Workforce

The Case for Change: (TVSCN Maternity Capacity and Future Planning Report, June 2016)

Most Trusts have flagged that the maternity workforce is an issue which is increasingly impacting on provision as more capacity is required.

Issues currently effecting recruitment and retention of workforce are:

- Increasing numbers of part-time workers – in most maternity units over 50% of midwives and support staff are working part-time.
- Age profile – a large number of midwives are due to retire within the next 5 – 10 years leaving a shortage of highly skilled and experienced professionals.
- Recruitment of Obstetricians difficult – obstetrics seen as a difficult and demanding specialty. Changes to visa regulations have made it impossible to recruit from overseas and the age profile of Consultant Obstetricians means a number will leave within the next 5 – 10 years. There are concerns that newly appointed Consultants are not as skilled due to the impact of the Working Time Directive; doctors will have effectively spent less time in clinical practice during their training.
- Retention of support staff at Agenda for Change Band 2 is problematic and there needs to be an agreed accredited career framework for this group of staff
- Changes to bursaries of student midwives (affective from October 2017), means that there will be a financial impact on individuals during their training. It is likely to impact on the more mature student because of lifestyle such as family commitments or those who have traditionally been seconded from the Trust on a salary. HEE must consider the impact of this change and how they will support students of the future.

Recommendations

TOPIC:	WORKFORCE			
	TVSCN	TV Senate	Better Births	NHS E : Workforce and Safer Care work streams
Recruitment & Retention	1. The introduction of a recruitment and retention premium similar to London weighting due to the high cost of living in Thames Valley.	4.11 Recruitment and retention was cited as a problem by all providers and it was agreed that within the collaborative arrangement, there would be an opportunity to work together to undertake recruitment and offer training and development opportunities across the Thames Valley.		
Collaborative Model – Job Role Capacity Review	2. The TVSCN strategic Heads of Midwifery and Lead Obstetricians group to explore workforce collaboration in the provision of maternity services e.g. FMUs, home births recognising that robust governance and vicarious liability arrangements would have to be in place.		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. 5 Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.	

	4. The TVSCN will work with Health Education England in the development of new roles within maternity such as: * Support roles * Registered nurses to care for high dependency women following the birth * Medical support roles	4.11 There would also be the potential to review new roles eg physician's assistant. The collective recruitment could bring additional benefits in providing a flexible workforce. 4.14 It was agreed that more could be done to maximise the potential of other clinicians in the maternity pathway including paramedics. In particular, it was agreed that GPs had expressed an interest in having a great involvement in maternity care for their population and more work was needed to understand what this could mean and what training would be required.		
Education / Training / CPD	3. HEE to explore financial options to support student midwives when the new bursary is implemented.			

			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 inspections. 5.1 Those who work together should train together. The Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists should review education to ensure that it promotes multi-professionalism. 5.2 Multi-professional training should be a standard part of professionals' continuous professional development, both in routine situations in emergencies. 5.5 Multi-professional peer review of services should be available to support and spread learning. CQC should consider the issue as part of inspections.	