NHS
North East London

NEL maternity and neonatal demand & capacity

Summary document

This document is a summary of the work that has been carried out as part of the maternity and neonatal demand and capacity programme

This piece of work is the starting point for exploring **how maternity and neonatal services in North East London can meet the changing needs of women and babies** and will inform how services in NEL in the future will meet the needs of local people through provision that is safe, high quality and accessible.

The first stage of this work has involved **understanding the current state**. This is through **collating and analysing data** to understand current activity and look at future demand projections, as well as **synthesis of existing work** done to date in NEL and national guidance, and **stakeholder engagement**. These findings have been brought together into a **case for change which identifies opportunities for the future**.

The second stage of the work was to **co-design best practice care models** for maternity and neonatal services, considering the opportunities identified in the case for change, national guidance and best practice examples. These care models were **developed with clinicians and wider stakeholders and** are intended as a starting point for future work

The high-level care models set out areas for further, data driven, exploration to develop more detailed care models that are deliverable, sustainable, make the best use of system assets, and deliver on the opportunities identified in the case for change.

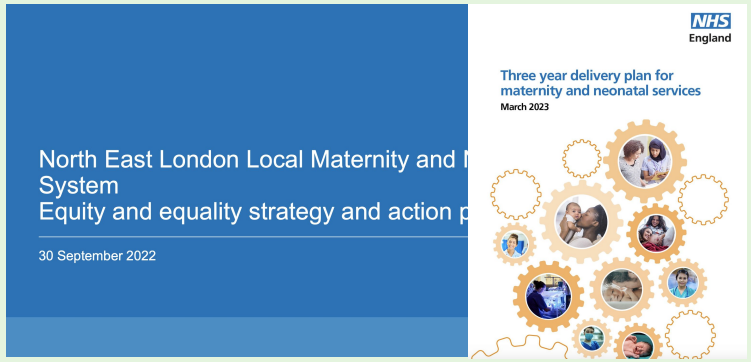
The case for change themes were developed through the engagement with stakeholders, desktop review and analysis and modelling

Stakeholder engagement

- Conducted 1:1 or small group interviews with over 50 stakeholders from across the system including service user representatives, Trusts, ICB, LMNS, ODN, LAS and Local authority colleagues
- Gathered views on current strengths of services, challenges and opportunities for the future

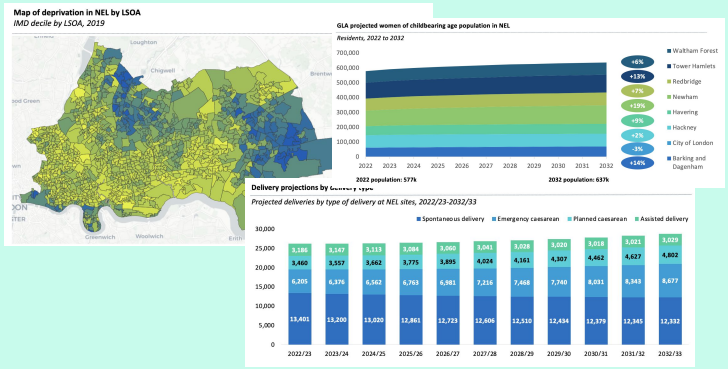
Desktop review

- Reviewed local NEL strategy, planning and work completed to date around maternity and neonatal services
- Reviewed service user feedback including from Healthwatch and CQC
- Reviewed national guidance and best practice documentation



Analysis and modelling

- Developed demand and capacity modelling to understand the projected future position in a 'do nothing' scenario
- Conducted further analysis including workforce, activity in and outflows and activity profiles by site



There is an opportunity to ensure maternity demand and capacity are matched across NEL, and to strengthen pathways and models of care to remove unwarranted variation

Matching demand and capacity across the system

- **Population growth** in NEL will outweigh a declining birth rate, which means that the NHS will need to support **more births** over the next 10 years
- Pregnancies and births are also **increasingly complex**, meaning **more resources are required for each birth**
- There is a need to **ensure capacity is matched to the needs of birthing people** in NEL

Strengthening antenatal and postnatal care pathways

- A high proportion of pregnant people in NEL have **other health conditions and may experience complex social factors** which mean their pregnancies are not low risk
- There are opportunities to **improve early booking** and **ensure effective communication**
- In addition to strengthening antenatal pathways, improving **pre-conception healthcare and prevention** is key
- **Postnatal care pathways** are a key element to contribute to improving health and care outcomes for families

Addressing variation in quality, access and experience

- **Service offer, pathways and processes are not consistent,** meaning pregnant people with similar needs have a different experience depending on where they choose to give birth
- There are opportunities to **ensure best practice is followed** (eg. around induction of labour)
- Service users report opportunities to improve access and their experience of care

Reducing health inequalities

- There are **stark and persistent inequalities in outcomes** for people from different population groups, for example, babies born to Black and Asian women are more likely to have a **low birth weight** and these women are **more likely to have a stillbirth** than White women
- Women in NEL are **more likely to book pregnancies later**, **particularly pregnant people from global majority communities**, which has implications for antenatal care and outcomes

There are opportunities for neonatal services to ensure care is delivered in the most appropriate setting, which will improve quality and safety

Delivering neonatal care in the appropriate setting

- It is important that neonatal care is provided in the most appropriate setting to ensure the highest possible quality of care is provided to each baby
- High occupancy levels in neonatal units increases quality and safety risks for babies; repatriating babies to LNUs from NICUs can free up vital capacity to care for the sickest babies
- Currently, **NEL neonatal units are experiencing high occupancy levels,** particularly at Royal London, and particularly in intensive care and high dependency
- There are opportunities both to **facilitate in-utero transfers** so babies are born in the appropriate care setting for their needs, as well as to ensure **repatriation of babies to their local unit** when they are well enough

Enhancing transitional care and care at home for neonatal services

- There is an **opportunity to improve transitional care across all neonatal units in NEL** to support improved discharge processes whilst maintaining contact between mother and baby, avoiding separation
- Transitional care supports the bond between the baby and their mother whilst maintaining support from midwives and neonatal nurses, which facilitates mothers being able to pick up issues more readily post discharge
- Developing the **neonatal outreach service** in NEL provides an opportunity to readily discharge babies and their families that require support which could be provided at home
- **Strong transitional care and outreach teams provide a better experience** for babies and their families whilst contributing to freeing up capacity on the neonatal unit at NEL hospitals

Stakeholders have described significant opportunities to ensure workforce models optimise the use of resources and prioritise staff wellbeing

Making the most effective use of staff resource

- There are **significant pressures on staff** across the system in both maternity and neonatal services with high **vacancy rates** and staff shortages being the cause of most escalations
- Alongside vacancies, **increasing acuity puts additional pressure on staff**, but the workforce model and model of care have not changed
- There is an opportunity to **optimise the future workforce model** to make best use of staff resources, ensuring **resourcing is aligned with case mix** and enabling staff to operate at the top of their skills and competencies
- There is also a need for **innovative approaches** to support recruitment in these areas

Improving staff wellbeing

- Stakeholders praise staff working in maternity and neonatal services as **hard-working, resilient and working together to provide safe care** in a challenging environment
- However, staff are feeling the pressure of the situation, increasing the **risk of burnout**
- NHS staff surveys show **reductions in staff morale and sense of wellbeing** in staff, particularly for midwives in NEL trusts
- Focusing on staff wellbeing is important for **their experience**, the ability to **retain and recruit** staff, as well as improving the **quality of care and experience for their patients**

The care models were developed based on a combination of national guidance, best practice and stakeholder engagement

- The case for change identified opportunities for improvement in maternity and neonatal services
- These opportunities provided a basis to understand what the future provision of maternity and neonatal services should be min NEL to best meet the needs of the population that they serve
- Considering the opportunities identified, initial drafts of future clinical models for maternity and neonatal services in NEL were developed based on best practice examples and national guidance including Better Births, Ockenden Report, the Neonatal Critical care review and BAPM Standards
- The care models were then shared and co-designed with clinicians and stakeholders in a workshop setting
- The current care models require further iteration with stakeholders in the next phase of work, so they can act as the basis for determining how services should be organized in the future and address all aspects of the case for change, including improving staff wellbeing

Maternity care pathway summary

This is a draft best practice model of care and represents how care could be delivered in the future and does not reflect the current care pathway

DRAFT WORK IN PROGRESS

Pre-conception

Pre-conception support

- General advice
- Specialist advice
- Perinatal mental health support

Access to care

Woman or person confirms pregnancy:

- Self-referral (online)
- Primary care referral
- Institutional referral
- Hospital referral

If needed

Central booking system for preference selection*

**Booking appointment*Helpline available*

- Risk stratification of all pregnant women including women being induced
- Personalised care plan
- Options to book interpreters for all appointments
- Social support advice
- Mental health support

Antenatal care

Choice of Site and birth plan

- Home birth
- Standalone Midwife led unit
- Obstetric led unit
- Alongside Midwife led unit

Routine care

- Advice and education (obesity, smoking, alcohol)
- Routine appointments, investigations & scanning
- Immunisation hub
- Health visitor
- Antenatal education & classes
- Diabetes support and care

Additional services if required

- Community / peer support / VCSE
- Antenatal screening +/- referral to fetal medicine
- Mental health support

Additional care / specialist input

- Maternal medicine pathway
- Fetal medicine pathway (incl. counselling and other specialist clinics)
- Diabetes/ other condition support & care
- Placenta accrete network

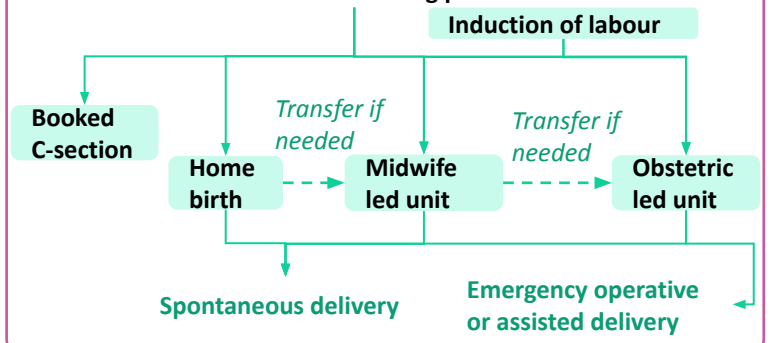
Birth and treatment

Care may be transferred to an alternative unit (patient choice or clinical indication) during the antenatal or birthing period or can be performed in-utero

Birthing

Triage of birthing location can occur earlier for a planned c-section

Triage to reassess suitability of birthing location and birthing plan:



If needed

Complications

Pregnant woman or person
- Maternity HDU
- Adult ICU

Baby – enhanced ward-based care
- Transitional care

Baby – neonatal care
- Neonatal outreach
- Neonatal unit (LNU / NICU) co-located with an obstetric led unit

Access to mental health support / risk assessment if needed

Postnatal care

Parent and baby

- Postnatal ward / readmissions
- Transitional care
- Specialist neonatal referral
- Feeding support
- Home visits
- Health visitor
- Neonatal community outreach
- Repatriation to local unit
- Social care support
- Long-term education for a healthy lifestyle

Post partum woman or person specific

- Primary care support
- Mental health support
- Physiotherapy
- Community midwife
- Family planning
- Bereavement support (across whole maternity pathway)
- Postnatal education
- Referral to other healthcare services incl. pre-conception
- Care for complex woman and people

Social prescribing is provided throughout

The maternity care model is split into four key phases with details around each to be iterated further (1/2)

Pre-conception and access to care

- Personalised pre-conception care for women or people considering pregnancy is key to support people to be in the best health before a pregnancy and increases the chances of conception, reduces the risks associated with a pregnancy, for example reducing the chances of a miscarriage or stillbirth, and optimise outcomes for the mother and the baby.
- These services should be community-based and delivered through proactive outreach, public health, social prescribing and the VCSE.
- Identification of people who should be signposted to pre-conception support services should be informed by risk stratification including demographic to target support to those who are most at risk of poor outcomes.
- Once someone identifies that they are pregnant, they can either self-refer to maternity services, or access maternity care via their primary care practitioner.
- There is an opportunity to provide a more streamlined approach to accessing care through a centralised booking system, providing a single point of access to book a first midwife appointment.

Antenatal care

- It is important that during the antenatal phase, care focuses on checking the health of the baby and pregnant woman or person, providing accessible information to support a healthy pregnancy and discussing the options and choices for care.
- It is important that previous birth experiences and baby loss are considered and targeted support provided as required. Additionally safeguarding and advocacy must be a core part of antenatal care pathways, as well as interpreting services for those who need them.
- The risk profile of pregnant women and people is increasing because of increasing complexity so access to specialist care and support must be optimised so that capacity matches demand.
- Multi professional working is key in understanding the right unit for a pregnant woman or person to book into for their delivery, particularly for those with co-morbidities.
- There must also be collaborative working across organisations including with public health, the VCSE and primary care, so that there is additional support for vulnerable women.

The maternity care model is split into four key phases with details around each to be iterated further (2/2)

Birth and treatment

- A pregnant women and people will be supported to make an informed choice as to where and how to give birth through the antenatal phase and this could be at home, in a midwifery led unit, or in an obstetric led unit.
- The profile of births in NEL has changed with the projected case-mix suggesting a greater share of more complex deliveries through planned and emergency caesarean deliveries and shift away from spontaneous, lower risk deliveries.
- Pregnant women and people need to be able to choose a place of birth that is best suited to their individual needs
- To provide the full range of choice, NEL would like to provide a standalone midwifery led unit as an option if feasible, but it is important that these units are sustainable and have sufficient staff to deliver high quality, safe care
- There is an opportunity to leverage learning from other hospital care pathways, such as inpatient elective care to optimise efficiency and use of resources for planned procedures. There is an appetite for further exploration of a hub for planned caesarean sections, for those whose medical needs are not highly complex.

Postnatal care

- High-quality postnatal care ensures that the mother and baby are recovering well and can have a significant impact on the life chances and wellbeing of the women or person, baby and family.
- Postnatal care can be provided to both the parent and baby or care that is specific to the post-partum woman or person and can range from routine care received following all births through to specialised care for the most complex women.
- Primary and community-based care will play a key role in providing equitable, high quality postnatal care for parents and their babies.
- Having postnatal pathways and services locally available to all residents makes it easier to navigate following delivery NEL sites and ensures that all women receive care in a fair and equitable manner.
- Currently it is mainly proactive women from affluent communities that make use of postnatal services so it is crucial that all women and people are made aware of the information and services that are available to them following their birth.

Neonatal care pathway summary

This is a draft best practice model of care and represents how care could be delivered in the future and does not reflect the current care pathway

DRAFT WORK IN PROGRESS

Labour | **Decision to admit** | **Inpatient stay** | **Onward care**

Triage to an appropriate site based on need

Choice of site can be made at any point up until the onset of labour

In-utero transfer to an alternative birth setting if anticipated level of neonatal care exceeds local availability with receiving units doing everything possible to take the transfer

Driven by BAPM standards

Delivery out of hospital with midwifery care

Transferred to nearest neonatal unit in the ICB

Presentation in labour at an Emergency Department

Delivery at an alongside midwifery-led unit

Admission to neonatal unit on site

Delivery at an obstetric-led unit

Transitional care can occur immediately after delivery if admission to neonatal unit is not required

Neonatal unit on admission (co-located with an obstetric unit)

Type of unit on admission depends on local availability:

- **NICU (level 3)**
- **LNU (level 2)**

Type of care provided:

- **Intensive care**
- *Step down in care*
- **High dependency care**
- *Step up in care*
- **Special care**

If needed

If specialist input is required

2 **Transfer between hospitals in the ICB**

NICU *Repatriation* **LNU**

Uplift

3 **Transfer to alternative NICU if specialist treatment is required**

Transfer to Royal London Hospital if specialised surgery is required

If needed

4 **Transfers to an appropriate level unit outside of the ICB**

Repatriation back to local hospital from specialist unit or unit outside of ICB

Transitional care on labour, neonatal and postnatal wards incl. feeding support

Mental health support for parents incl. wellbeing support

Community neonatal outreach

Outreach from the specialist hospital

Postnatal midwifery review and support for maternal health

Baby specific

- Repatriation to LNU closer to home
- Follow-up appointments (neonatal or paediatrics)
- Multidisciplinary team follow up
- Specific neurodevelopmental follow up for high-risk infants
- Primary care follow up
- Hospital at home services
- Feeding support
- Referral to social/palliative care
- Neonatal community outreach

Pregnant woman or person specific

- Onward referral
- Postnatal education
- Mental health support
- Primary care input
- Community midwife
- Physiotherapy
- Family planning advice
- Bereavement support
- Community support groups and networks
- Social care
- Referral to other healthcare services inc. pre-conception

The neonatal care model has three phases and will be subject to iteration in the next phase of work (1/2)

Labour and decision to admit

- To ensure care is delivered in the most appropriate setting, pregnant women and people would be advised to deliver at a unit where the level of neonatal support available is in line with their baby's anticipated needs.
- Babies that are expected to be at the highest risk of needing support from intensive care will deliver in an obstetric unit with a co-located NICU (level 3), aligned to the BAPM standards.
- Babies can be transferred in-utero transfer to an appropriate birth setting would ideally be undertaken to prevent mother and baby separation when there are unexpected complications which require an uplift in care
- Coordination across units in NEL could include establishing neonatal units as a single bed base for neonatal care which would be centrally managed and would enable collaboration between sites to manage flow
- Neonatal transfer and transport services with sufficient capacity to meet demands are critical to support this

Inpatient stay

- All neonatal inpatient care in NEL would continue to be delivered at either an LNU or a NICU; inpatient capacity at both levels needs to be aligned to demand
- The future care model should clearly define the catchment population for NEL and aim for all babies within that catchment area to be able to receive care within the system
- Capacity also needs to be sufficient to meet the needs of babies from other systems needing NICU care
- If a baby requires an uplift in care, they may require a transfer to another unit within or outside the ICS, or to a specialist hospital. A transfer for an uplift in care would typically result in a move from an LNU to a NICU.
- If a baby has been transferred for an uplift in neonatal care, they will be repatriated back to their closest LNU at the earliest opportunity where it is safe to do so. Enhancing repatriation processes ensures that the baby and parents can be as close to their family and support network as possible.
- The proposed care model would have a set of objective criteria for repatriating babies back to their local neonatal unit from the NICUs in NEL, utilising the neonatal ODN repatriation guidelines.

The neonatal care model has three phases and will be subject to iteration in the next phase of work (2/2)

Onward care

- An enhanced, properly funded Neonatal Transitional Care service will facilitate the smooth transition of care from a hospital setting back into the home setting following discharge.
- Transitional care will allow mothers and babies to be cared for together away from the neonatal unit, freeing up crucial capacity to allow for babies to be cared for in the most appropriate setting.
- Following discharge, babies and their families would have access to a range of onward care support services.
- A key aspect of the onward care will be the neonatal outreach service which will be operational 7 days a week and will provide care for these service users in the community setting and at home.
- Stakeholders expressed a desire to explore the opportunity to expand hospital at home services to include neonatal care to provide care away from the hospital setting where feasible.
- The future care model will have clear guidance on the step from neonatal to paediatric care across NEL to ensure that high quality, safe care continues for service users.

There are key enablers for the effectiveness of the proposed care models (1/2)

Culture of collaboration	• Developing a culture of collaboration across the ICS is a key condition for the future success as the draft care models are reliant on organisations in NEL working together to provide care that is centred around the service user. • It is crucial that all stakeholders deliver maternity and neonatal care as **one system** with individual organisations working as collaborative parts within the overall system, and service users experience a seamless set of services
Communications and engagement	• Clear and consistent communication across NEL is key to developing trusted relationships between organisations. • Engaging with other hospitals breaks down existing siloes and creates teams that want to work together which positively contributes to the development of a culture of collaboration. • It is important that communication is enhanced across all parts of the maternity and neonatal pathway
Digital and information systems	• Currently not all units are linked together, with some units still using paper records which limits the effectiveness of the care model. • An interoperable connected system would improve the way in which the organisations within NEL can work together by accessing data in a readily manner whilst facilitating transfers and network working.
Technology	• Enhancing the provision of technology across services in NEL is crucial in ensuring that care can be delivered effectively and productively in a capacity constrained system where demand is projected to increase. • The population has changed since these services were first designed and technology is key in making best use of the current configuration of space within the units in NEL.

There are key enablers for the effectiveness of the proposed care models (2/2)

Workforce strategy

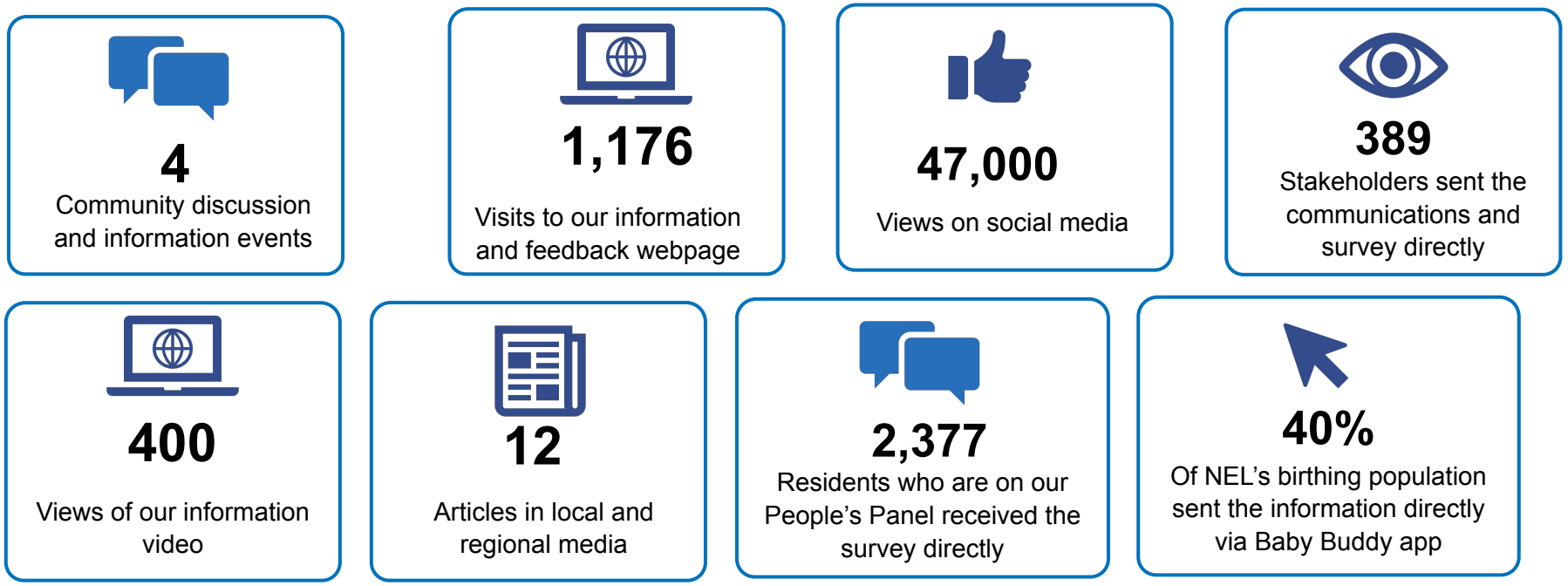
- Developing a workforce strategy in NEL is crucial to the future success of the proposed care model to ensure that staff resource is being most effectively whilst considering their overall well-being.
- Looking after the workforce in maternity and neonatal services is key for the future success of the care model as will encourage staff buy in whilst improving retention and recruitment.
- Staff should feel heard regarding their ways of working preferences with consideration of their preferred work-life balance where possible through flexible working patterns with careful consideration.

Estates and resources

- The proposed draft care models require estates and resources to be aligned to the pathways that have been developed to ensure the success of the care model in the future.
- This may require a degree of flexibility within how estates are configured to ensure that there is sufficient space and resources available to meet the proposed pathway changes.
- The current estates were not built for the world that we have now and as such it is important to map the future requirements of the proposed care model to what the estates are currently to understand any gaps in consideration of potential capital constraints.

How we engaged the public

- We ran public engagement on the Case for Change from 16 July – 8 September 2024, this included time outside of the school holidays
- The case for change and how to have our say on it was promoted widely to the public, stakeholders and staff over this time using a range of communications channels
- We engaged seldom heard groups, representatives of our communities, and families.



Public feedback on the Case for Change

We heard from almost 500 people, through a mix of discussions, meetings, presentations, written feedback and survey responses.

- 53% of respondents had had a baby that was cared for in a neonatal unit
- 64% of respondents were residents, others were NHS staff
- 94% of respondents understood why services needed to change
- 94% of respondents also agreed with the need for change

499

Responses received

94%

Understand and agree with the need for change

Public feedback on the Case for Change

We are currently doing a detailed analysis of the feedback. From what we know so far, below are the areas of the case for change which have come out as key areas of priority based on the response from the public:

Matching demand and capacity across the system

Making sure we have enough of the right care in the right place

Delivering neonatal care in the appropriate setting

Delivering care to newborn and ill babies in a place that is best for them

Strengthening antenatal and postnatal care pathways

Improving advice and support before and after pregnancy, and pregnancy loss, ensuring it is clear and accessible.

Addressing variation in quality, access and experience

Always showing kindness, respect, compassion and cultural awareness

Next steps

- The feedback, views, ideas and suggestions on our Case for Change are being used to inform potential future care models for maternity and neonatal services.

- They will be based on all this information and insight as well as best practice examples and national guidance including Better Births, Ockenden Report, and the Neonatal Critical care review

- Again this is being done in together with experts, clinicians and community representatives and is underway

- We are anticipating having these potential future models of care in the next few months

- No decisions have been made yet and when we have some options for how future maternity and neonatal care could look in the future we will share these with you and the public for your views so you can continue to help shape them.