Annex 1 Acute Care model update

1. Adult Urgent Care pathways

A. Community based pre hospital care

1.1 The out of hospital acute care model starts in **primary care** working with community services and secondary care specialists. The management of long term conditions at home, supported nursing home based care and the practice of acute diagnostic assessment outside of an acute hospital setting, are key foundations to avoid the need for admitted acute hospital based care.

1.2 Innovation through the **use of population health data to predict ill health** or falls for example, will inform planned and proactive community intervention. Application of data will enable stratification of the local population, directing preventative and responsive interventions to the right people at the right time. There is a significant programme of work and redesign to be fully scoped and commissioned that transitions community services from being reactive of health needs to data assisted predictive care which supports the intensity of personalised care to avoid hospital admission and maintains patients care safely at home. **Data will be used as intelligence to inform care planning and escalation of care.** This will be a big change in the way we work.

1.3 The **most complex patients who require an intensity of community based care will have a core Multi-Disciplinary Team (MDT) practising holistic personalised case management.** The MDT will work to avoid admission utilising virtual speciality MDT's, hot (urgent) clinics, Same Day Emergency Care and step up care into a sub-acute community bed base if required. Priority patient groups will include frailty, respiratory, heart failure, diabetes and neurology. Intelligence will include the use of patient own diagnostic data and the patient portal in our electronic patient record. Membership of the MDT will reposition existing staff to work differently and must include psychologist expertise as well as pharmacy to manage patient's well-being and medication reconciliation respectively.

1.4 **Expanding the range of community based diagnostics places acute care into the community.** The new EPICENTRE service starting in 2020 is an Emergency Point of Care Testing and Treatment service In Care Homes and at Home. This is a unique pioneering acute care model outside the walls of a traditional hospital setting. With point of care blood testing and results available within minutes and point of care ultrasound in conjunction with senior decision making, an integrated acute medicine and community based advanced clinical practitioner team aim to provide acute care management within patient's homes without transfer to hospital. Quarter 1 will be used to baseline the potential impact the service.

1.5 **Discharge to assess models of social based care** are proving successful in Birmingham, reducing community bed days in the medically fit for discharge (MFFD) bed category. Similar models are being rolled out in Sandwell. The advantage to this discharge assessment model includes avoidable complications associated with unnecessary acute

hospital stay and patient assessment out of hospital better optimises community based care to support quality of life at home.

1.6 As the **need for MFFD beds declines**, the new ways of working of predictive and interventional coordination of escalating care needs via the community MDT will result in **increased step up use of community beds for therapeutic care, respite or neuro rehabilitation.** It is anticipated that this will increase step up pathways from circa 5% to 20% of our admissions into community beds. The provision of specialist therapy and nursing care across the community bed base will facilitate patient centred therapeutic intervention to improve patient outcomes. We will continue to provide responsive in-reach community services into Care Homes preventing avoidable hospital admission.

1.7 **The 3rd sector** already provides crucial support to our population. The complexities of the Birmingham and Sandwell variances which could unintentionally result in inequitable experience for patients on a single acute site needs to be worked through. For essential pathways that interface with hospital based care, we will need to see partnerships created across the 3rd sector and potential support by the Trust Charity.

1.8 Merging the multiple **Single Points of Access** that exist for primary care access into secondary and community care to one point of access will streamline access to integrated care services for GPs, social care and patients. This will reduce time to refer and improve access to appropriate pathways, avoiding treatment delays. Partnership work with neighbouring providers will ensure onward community care is facilitated regardless of patient postcode. The **front end of the ED pathway will remain GP led**.

B. <u>Emergency Department</u>

1.9 A programme is already in train to establish the **new Urgent Care Centre at Sandwell** in 2021. The Urgent Care Centre will remain on the Sandwell site once MMUH is open.

1.10 The design of the 2nd floor at MMUH and visible WMAS (ambulance) electronic patient record enables trusted assessor pathways **from WMAS paramedics direct to diagnostics or treatment** avoiding ED ; these include:

- WMAS – primary PCI – direct to Cardiac Catheter Lab then Cardiology Ward
- WMAS – suspected stroke – direct to CT and then Hyper Acute Stroke Ward
- WMAS – suspected but stable hip fracture – direct to radiology and then SAU or home with community follow up

1.11 **Immediate 24/7 senior clinical assessment** in the **Emergency Department** (ED) is essential to drive safe and timely pathways with early diagnostics either through the ED or direct to alternative urgent care settings including scheduled primary care same day appointments.

1.12 Patients walking into ED will be offered **self-check in facilities** which will cater from multiple languages. The digital journey displayed in the ED walk-in arrival area will inform patients of their anticipated journey and associated waiting times.

1.13 **Point of care testing and condition specific order sets** will be optimised to inform earlier and appropriate diagnostics. **Artificial intelligence** (AI) will support evidence based decision making in respect of radiology tests results, optimising radiologists work flow and clinicians treatment decisions.

1.14 Based on senior clinical assessment and early and responsive diagnostics, **a 'push model' of pathways to assessment areas will become the norm**. Patients in need of clinical stabilisation will be seen by relevant specialists on a 'pull model' into ED. The locational adjacencies of ED and the assessment units facilitate this cohesive working alongside cultural change. ED senior clinicians will have the authority to move people from the department after their initial assessment to a more appropriate pathway of care outside the emergency department. Consistency must be achieved in clinical response standards of senior clinical review in ED within 30 minutes of referral to specialities and patients requiring critical care admission to be admitted in less than 6 hours to ensure timely and safety driven clinical standards.

1.15 The scale of **ED** is such that it will no longer be run as a single department with a nurse and senior doctor in charge. **Zonal coordination** of resus, majors, minors, paediatrics and urgent primary care will be a necessary leadership delivery model. This requires standardisation of practice and clinical leadership capability to work the zonal model. The zones will report into a coordination hub where a consultant and nurse will oversee the department against a set of clinical operating standards and exceptions, with good visual management across the department. Zonal oversight will be supported by digital dashboards and electronic patient clinical views at zonal level.

1.16 The communication skills between zonal teams and zones to step levels of care up or down will be enabled via a **wireless person specific voice driven communication technology**, which facilitates immediate verbal communication by role at a distance. This will be purchased in 2020 for implementation to improve communication and flow within the department. Optimising communication messaging apps and abolishing the bleep system will enhance timely communication with specialities.

1.17 A **mental health assessment** facility sits adjacent to the ED. The Trust currently has 2 psychiatric liaison services which need to function as a single service experience.

1.18 **Mental health liaison staff will be alerted to jointly triage and assess patients** presenting with mental health symptoms. This new approach to joint triage ensures early consideration of admitted and non-admitted pathway and treatment options.

1.19 Patients who are medically cleared will be transferred to the adjacent **mental health assessment unit for ongoing assessment and care, which will be staffed 24/7.** This new facility is advantageous to patients who will be cared for in a dedicated mental health assessment facility outside of a busy ED environment by mental health specialists. It will also free up ED cubicle space which is inappropriately used for patients waiting for mental health beds externally, who are otherwise medically fit and do not require emergency care medical input.

1.20 Working with Birmingham City Council, we have in principle agreement of a workforce model that locates an **AHMP on site in ED 24/7**, avoiding very long waits for formal mental health assessment and undoubtedly improving outcomes. This is a significant workforce change and improvement in patient experience.

C. Same Day Emergency Care and Acute Assessment

1.21 There has been a conscious renaming of ambulatory care to **Same Day Emergency Care.** This aligns with national standards and distinguishes the difference between planned or scheduled ambulatory care.

1.22 There will be an overwhelming emphasis on Same Day Emergency Care to further expand and develop to take a proportion of the acute medical take and continue with follow up reviews. This creates a robust safety net to **avoid admission and safely discharge patients home.** Early and responsive diagnostics again are an essential component of the service model.

1.23 Same Day Emergency Care will be mainly delivered by **Advanced Clinical Practitioners** (ACP's) to assess, treat and discharge patients directly streamed / scheduled from ED, GP's and the Single Point of Access (SPA). This is a significant workforce development. Working with academic partners, we aspire to become the employer and educator of choice for ACP's. The intention is to appoint professional and academic leadership to develop this workforce in 2020.

1.24 **Sickle cell and thalassaemia day care** is available in MMUH for both urgent care non admitted pathways as well as planned day case treatment.

D. Admitted and speciality based care

1.25 **The adult inpatient admitting model** will be based on ED, Acute Medicine and Critical Care consultant led shifts 7 days a week. This will include an initial senior clinical review within 14 hours of admission and ongoing daily review to meet the national clinical 7 day service standards, which are aimed at improving clinical outcomes and reducing inequity of service between weekday and weekend. Clinical teams aspire to meet the Society of Acute Medicine guidelines of review within 8 hours during the day time. This requires recruitment, workforce planning and redesign of rotas within budget with key admitting specialties such as respiratory and older people's medicine to integrate into the acute medicine workforce which is the most significant workforce risk based on current state.

E. Older People and Frailty

1.26 **The older people and frailty model** for the future will be designed to avoid unnecessary admission and continue community or nursing home based care. The vision for older people and frailty is better developed and will involve a significant change from current practice. Pilots focussed on frailty patients presenting direct to ED are showing promising results in terms of avoiding unnecessary admissions but a detailed holistic

strategic service plan needs completing before Christmas to ensure development of the service over 2021.

1.27 The **main cohort of patients will be at home** or in care homes. Advanced care planning and documentation of that plan in **patient passports** and the patient portal will enable efficient escalation of care in a planned way to the right place of assessment and care. This would include direct admission to Same Day Emergency Care, acute assessment or end of life facilities etc bypassing ED.

1.28 Use of **predictive population health data** will enable intervention and preventative care; eg; we can predict your fall, your readmission etc and mitigate potential impact through a responsive MDT. A virtual MDT using existing staff differently inclusive of a pharmacist for medicines reconciliation and specialist assessment will manage escalations of care.

1.29 The Geriatrician and Community ACP led pilot triages GP, SPA referrals and patients attending ED. **Rapid diagnostics and assessment avoid admission and enable safe discharge home with support.** Patients requiring slightly longer assessment will be reviewed in the Same Day Emergency Care or acute assessment units both of which have frailty zones.

1.30 In MMUH **inpatient older peoples services** will be ward based, with a virtual community in-reach model to all inpatients beds to support frailty. Orthopaedic wards already have older peoples consultant led care. The virtual ward effectively establishes a 'pull model' of well-planned discharge into community based care either via step down community beds for further therapeutic care which would suit post orthopaedic surgery, or community supported care at home. The 'pull' model will include pre-assessment for planned surgical intervention of older people with community and social care input where appropriate.

F. <u>Respiratory Care</u>

1.31 **The respiratory service model** encompasses community based care right through to critical care and full life support.

1.32 Similar to the broader community and older people model, acute care will be managed in the community. A new way of working will oversee patients at home with long term respiratory conditions being case managed via a MDT, who will review predictive data intelligence and patient's own diagnostic results. Updated disease registries are essential. Early signs of deterioration will initiate a rescue response. The MDT will utilise existing staff differently and include community based staff, psychology expertise and respiratory physiologists.

1.33 **Advanced care planning** and documentation of that plan in a patient passport and via the patient portal will enable direct access to specialists via Same Day Emergency Care, hot clinics or admission avoiding unnecessary ED attendance.

1.34 **Enhanced respiratory care** will be provided in the inpatient setting inclusive of Non Invasive Ventilation (NIV), Continuous Positive Airway Pressure (CPAP) and high flow oxygen. This unit will be led by the respiratory team with expert nursing and therapy input. The team will also be scaled to in-reach via a virtual ward to critical care daily, respond to alert calls for ED acute respiratory presentations and review respiratory patients on other wards who have underlying respiratory needs and are at risk of deterioration.

1.35 **Community membership of the virtual ward** effectively establishes a 'pull model' of well-planned discharges into community based care either via step down community beds for further therapeutic care or community supported care at home.

1.36 Given the significant service developments in the above model, thought needs to be given to leadership and change capacity given this speciality's workload in the current pandemic.

G. Stroke and cardiology

1.37 Both stroke and cardiology services are reliant on timely access to CT and cardiac catheter labs. Paramedic trusted assessor pathways and access to the ambulance electronic record with pre alerted patient arrivals to ED, will ensure direct access to diagnostics and early treatment interventions which are located on the same floor as ED. This is a new way of working which is practiced elsewhere.

1.38 Enhanced care will be provided in the hyper acute stroke and coronary care facilities based on the respective speciality ward.

1.39 A therapy hub is located on the stroke ward to aid very initial acute rehabilitation.

2. Diagnostics

2.1 **The diagnostic facilities in MMUH are for urgent care or admitted patients only.** Planned care diagnostics will take place at the off-site treatment centres. The utilisation of diagnostic kit in MMUH will be lower than currently experienced and afford fairly immediate testing. The impact of this aligned the use of artificial intelligence and reporting of tests within a maximum of 24 hour, will improve time to treatment and ultimately reduce length of stay.

2.2 Engagement with clinical teams shows consistent aspirations to optimise the availability of diagnostics and get the **right test first time**. Specified quality referrals and use of artificial intelligence to vet referrals will enable radiologists to advise on the best test, agile diagnostics will allow procedures to take place outside of a theatre environment, evidence based protocols avoid unnecessary tests, the impact of which is earlier clinical decision making.

2.3 The radiology leadership team are advocates of clinical teams coming together into multi-specialty areas for **learning to improve clinical integration**, **education and patient**

outcomes. That effective joint working needs to become the norm now to work through evidence based changes in diagnostic protocols and advance the AI capability.

3. Adult Surgical Pathways

3.1 Most **Surgical services are already located on the same site** so are used to working at a similar scale to that designed in MMUH.

A. <u>General Surgery</u>

3.2 The colocation of ED, **Surgical Emergency Ambulatory Care, Surgical Assessment Unit and radiology will transform patient pathways.** Stratifying abdominal conditions to early CT from ED initial assessment will avoid multiple radiology tests and provide diagnostic decision making information early in the patient pathways to inform surgical intervention. 7 day JAG accredited endoscopy will also be available.

3.3. **Surgical Same Day Emergency Care** with it's adjacency to ED, has an overwhelming opportunity to streamline pathways direct from triage and utilise the available diagnostics to expand pathways of non-admitted surgical patients traditionally seen in ED eg; renal colic. Immediate ultrasound provision is critical to decision making and will be provided by radiology. Patients will then be discharged home, admitted to the Surgical Assessment Unit or booked into day case surgery. The Emergency Gynaecology service model (EGAU) will be transferred to MMUH providing similar same day emergency care and treatment.

3.5 **Planned ambulatory surgery as day case procedures** will largely take place in a separately located treatment centre at Sandwell or City hospital sites**.** These pathways exist already and need to be scheduled to a treatment centre once MMUH is open**. Same Day Emergency Care that includes day case intervention will be scheduled at MMUH**, with patients recovering in the theatres recovery area and in the chaired area on the surgical ward before being discharged.

3.6 An **inpatient ward based speciality model with combined gastroenterology and gastrointestinal surgery** brings advantages to shared aspects of care. Collocating surgical and medical gastrointestinal specialities will enable shared care for some patients including a level 1 critical care facility, improved access to dietetic advice and a 7 day stoma care service. We have an opportunity to practice much of this on the Sandwell site prior to MMUH opening.

3.7 As well as joint working in MMUH, the team would case manage patients to avoid unnecessary admission through hot clinics and Same Day Emergency Care or access to the right care including end of life care.

B. Trauma and orthopaedics

3.8 With **immediate access in ED to radiology**, evidence based pathways will be revolutionised towards earlier treatment.

3.9 The speciality will share Same Day Emergency Care and Surgical Assessment facilities with surgery **benefiting from insitu procedure and plastering rooms outside the ED.** This will require a well-practiced and consistent 'push model' from ED to orthopaedics based on agreed clinical pathways, to avoid unnecessary patient waits in ED. Same Day Emergency Surgery will take place in the MMUH operating theatres.

3.10 **Patch and Plan** pathways for surgical procedures planned over 24 hours from emergency presentation will be scheduled to a treatment centre as will the fracture clinics. This takes this speciality to 3 site working and needs the staffing model to adapt to this.

3.11 **Orthopaedic and older people wards will be collocated** on a single floor with therapy hubs to facilitate early therapeutic intervention, albeit there are a range of areas in which this can potentially take place such as the winter garden and outdoor space.

3.12 **Early supportive therapeutic step down pathways** to a community bed will progress care to safe discharge effectively.

C. Specialist Surgery

3.13 ENT, breast, ophthalmology, urology and vascular surgery will be largely practiced at the treatment centres. There are some opportunities to consider in terms of diagnostics and patch and plan pathway specific enhancements based on best practice.

D. Theatres

3.14 City and Sandwell **inpatient and emergency theatres** will need to be standardised to collocate at MMUH. The theatre suite has adjacencies to preadmission and recovery care.

3.15 **Robotic assisted surgery** provides improved access into hard to reach areas, as well as enhanced vision, precision and control. Patients have less post-operative pain, a reduced risk of infection and less time in hospital. Surgical leaders are making a case for robotic surgery for urology, general surgery and gynaecology as part of the future clinical model. This would also support research and recruitment to the university hospital environment.

4. Care of the critically ill patient

4.1 **Level 2 (high dependency) and 3 (intensive)** care will be provided in the critical care unit. **Level 1** care is designed to be as now provided in speciality based ward areas of

acute assessment, Gastroenterology /GI Surgical ward, Gynaecology, Respiratory ward, Cardiology and Stroke, maternity and the post anaesthetic recovery unit.

4.2 **Enhanced care** is a new intermediate level of care between level 1 ward based care of patients at risk of deterioration and level 2 which is high dependency care. Enhanced care is a higher level of care then level 1 requiring monitoring and intervention on a ward.

4.3 Enhanced care is likely to be localised on cardiology's coronary care unit (CCU), the Hyper Acute Stroke Unit (HASU) and the post-operative recovery unit. With standardised competencies this **ensures dispersed critical care skills outside of critical care onto the ward areas**. Supported by telemedicine, a virtual multi professional team will be alerted to potential and early patient deterioration. Effectively a virtual ward via Unity can be set up to bring Level 2 and 3 critical care skills to ward based teams. The final decision on the enhanced care model, which could include enhanced care in other level 1 areas, will be made via the critical care board.

4.4 The adjacency of the respiratory level 1 non-invasive ventilation facility to the level 3 critical care unit, is helpful in terms of centralising escalated respiratory support and ventilation requirements such as those resulting from pandemic related increased demand. The overall design of MMUH works in a pandemic scenario.

5. Inpatient Wards and therapeutic care

5.1 **Inpatient wards** are based on floors 6, 7 and 8. Inpatient specialities include GI medicine and surgery, haematology, toxicology, acute stroke, cardiology, older people adjacent to orthopaedics who have dual medical and surgical input and gynaecology. There is space technically being commissioned on the 9th floor for inpatient wards.

5.2 **Specialities** largely move from a single site or from 2 sites to 1. The latter scenario could include the merger of 3 or more ward teams. There will be significant team development work within the readiness programme to be designed and delivered. Stroke decouples acute services into MMUH and leaves rehabilitation services at Sandwell. The stroke services input to the rehabilitation ward needs defining.

5.3 **Wards will be standardised** in their layout and basic principles of how they function. To enhance safety and staff effectiveness, there will be significant standardisation applied to the wards inclusive of:

- Equipment – location of essential safety equipment such as resus trollies, sepsis boxes, pharmacy and IT will be standardised to enhance responsiveness and safety.
- Stores and clinical supplies will be standardised with 80% of the same layout of stock on the wards.
- The patient's day will be transparently planned with schedules of tests, procedures and ward rounds published.
- Visiting times and experience will be standardised with welcome areas and information for families and carers.

- Shift times will be standardised (yet be inclusive of flexibility) to align with the hospital day.
- Information – measures of success both staff and public facing will be published on digital screens.

5.4 Given the current variability in practice we intend to **learn from other industries** such as automotive production and the airline industries on successful cultural change, implementation and sustainability to achieve the benefits of standardisation.

5.5 **The high single side room ratio** will change both the staff and patient experience. The 50% ward side room ratio improves privacy and dignity of those patients at end of life and for their families. Infection control is a significant safety benefit building on our good track record for infection management. Outbreak and pandemic management will be massively enhanced with one of the largest provisions of negative pressure ventilation rooms per bed base nationally.

The experience and benefits of the side rooms will also be opposed by potential challenges of patients feeling unnecessarily isolated in terms of visual oversight and the opportune communication with staff one can get on an open ward. The rooms are designed with good visualisation between staff and patients. Technology with voice assisted patient call systems will be incorporated into new ways of working. Culturally we need to support staff working in this different environment.

5.6 **The Therapeutic Care model will not be solely ward based.** The new MMUH environment both within and outside the building offers new opportunity for our therapeutic care offer such as**:**

- Understanding patient preferences and home routines to emulate those in hospital eg; bed time and day time routine, hobbies and interests.
- A good night's sleep with sleep support packs and day time dressing for many patients will be a visibly practiced. The day light exposure from large windows in every bedded area will help orientate patients to day and night easily.
- Use of internal and external space for personalised therapeutic care informed by patient preferences and can include participation in activities hosted in the winter garden or outdoors, use of walkways including the permanent art exhibition area and use of ward patient kitchens to support independence.
- Dementia friendly activities will be planned in the wards as well as the winter garden and outdoor space supported by activity coordinators and volunteers.
- Patient support groups and 3rd sector organisations will be encouraged to use 'space' in MMUH and add to the therapeutic care model.
- Partnerships with colleges and local businesses can bring in hairdressers, dressers, additional well-being activities and in-reach exercise activities that can continue at discharge.

5.7 **Supporting care for early and safe discharge with social care partners** starts on admission. The entirety of the health or social care community bed stock will be

transparent to all partner organisations. Practices related to assessment, electronic referral and discharge will be standardised in advance of the move to create postcode blind pathways with both social care providers. The experience for patients and staff will be uniform. The standardised electronic information sent to trusted assessors making informed decisions about levels of care on discharge, will enable more timely decision making. A 24 hour post discharge follow up by social care service to care homes will repeat the benefits of the acute and community follow up intervention which decreased readmissions and ED attendances.

6. Children and Maternity pathways

A. Children

6.1 The totality of children's services will be provided at MMUH including outpatient services. The children's acute care model is about providing treatment in the right place at the right time by staff with the right skills. **The child will be at the centre of all decisions**, with family choice taken into consideration too.

6.2 The **out of hospital acute paediatric care model** starts in primary care working with community services and secondary care specialists. The management of patients with long term conditions at home, point of care testing with rapid results and a new children's **ICARES hospital at home team**, are key foundations to avoid the need for admitted acute hospital based care and support safe and early discharge .

6.3 **Senior clinician triage of GP and SPA referrals**, use of hot clinics and a Same Day Emergency Care model will avoid the need for ED attendances and reduce the need for hospital admission.

6.4 **Immediate 24/7 senior clinical assessment in the Emergency Department** (ED) follows the adult care model for children with immediate access to diagnostics.

6.5 **Children's Mental Health** would be improved by on site mental health services. The future state urgent care specialist service and onward pathways is under review with the CAMHS service. Similar to adult services, the on-site psychiatric liaison team will be alerted to jointly triage and assess children presenting with mental health symptoms. This ensures early consideration of admitted and non-admitted pathway and treatment options.

6.6 The current service offer by external providers remains inadequate particularly in terms of Tier 4 bed which remains on the trust risk register.

6.7 The current 2020 new adjacency of ED and PAUs at City hospital will enable joint working under **single speciality leadership for the urgent care children's service and create pathways of care to be replicated in MMUH**. The integrated workforce model

between ED and PAU, with single speciality leadership likewise will be replicated into MMUH.

6.8 **Paediatric surgery and day care treatments** will take place at MMUH. The inpatient bed base will include dedicated adolescent beds.

6.9 **Critical care facilities for children** will include HDU and a respiratory level 1 facility for non-invasive ventilation and continuous positive airway pressure treatment.

6.10 **7 day consultant led standards** will be in place for children and maternity services and will meet the service standards of 14 hour post admission and daily consultant reviews. Recruitment to meet those standards is in train.

6.11 **Supporting care for early and safe discharge** with supporting community services will include achieving the quality plan goals of improving school attendance time. As with adult care practices the assessment, referral and discharge processes will be standardised to create postcode blind pathways with both social care providers. The experience for patients, carers and staff should be uniform. Supporting care through ongoing education will include parent forums, school engagement, GP forums and WMAS training.

6.12 The **Therapeutic Care model for children** similarly to adults benefits from the winter garden and outside space which can incorporate daily physical, mental well-being and learning activities.

B. Maternity and neonatal care

6.13 Maternity and neonatal services are currently on a single site.

6.14 To enhance integrated care foetal medicine will be more community based through locally placed hubs with increased community screening capacity. The locations need to be confirmed.

6.15 Access to maternity for women presenting on a planned pathway is via a dedicated entrance and direct lift to access the 3rd floor services. The delivery suite and neonatal unit are adjacent on the 3rd floor with post-delivery care on the 4th floor. ED is also resourced to deliver babies for women presenting in emergency situations and the ED team will be supported by an alert call to the maternity team to support emergency deliveries.

6.16 The relocation of maternity services on an acute hospital site benefits in terms of diagnostic facilities including interventional radiology and closer adjacencies to critical care. Neonatal facilities remain adjacent to the delivery suite and are also near to critical care which can enable joint critical care learning, development and working.

6.17 The maternity services are working towards a full Continuity of Care offer, where the same midwife cares for women throughout the pregnancy, labour, birth and post birth.

The impact of such continuity can achieve improved clinical outcomes and higher satisfaction rates.