

# Maternity Services Strategy

2009 - 2012



## Version control

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# Foreword

The PCT's in East Sussex are committed to the development and delivery of flexible, accessible individualised maternity services designed to fit around the needs of a woman and her baby. We recognize that giving birth can be one of life's most rewarding experiences and we want to ensure that this is possible for everyone. Our priority is to support and encourage women to have as normal a pregnancy and birth as possible with full access to the best and safest healthcare services.

Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies, on the healthy development of children and on their resilience to problems encountered later in life. The National Service Framework (NSF) for Children, Young People and Maternity Services sets out the need for flexible services with a focus on the needs of the individual, especially those who are more vulnerable. Maternity Matters consolidates the government's vision and priorities for modern maternity services including a stronger focus on governance, quality assurance, developing outcome based services and the impetus to deliver a wider range of localized services geared to local needs.

This document outlines a three year strategic direction for improvement, to achieve first class care across the whole maternity pathway and describes how we will go about developing a modernised, woman-focused and family-centered maternity service. Much of the detail relating to "how we will achieve our strategy" is contained in the Maternity Strategy action plan whilst our vision, commitments, service priorities and governance/monitoring arrangements are set out in the main document.

The development and implementation of this strategy responds directly to the recommendations made by the Independent Reconfiguration Panel (IRP) in developing a strategic direction for maternity services and effective model of care. Since January 2009 a Maternity Services Development Panel (MSDP) has been set up as a project board to drive forward the implementation of the IRP recommendations on behalf of the Joint Committee of the PCT Boards. The MSDP effectively completed work on implementing the following recommendations:

- Developing a model of care that ensures the continuation of consultant-led maternity services, special care baby services and inpatient gynaecology services in both Hastings and Eastbourne.
- Ensuring that improvements to antenatal and postnatal care and associated outreach services are implemented without delay.
- Developing a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the IRP recommendations.

The more detailed on outcomes from the work and description of the agreed service model and key linked services are contained within this strategy, including the provision of obstetric, gynaecology, paediatric and neonatal services in acute settings.

Offering choice over where and how to give birth will lead to more flexible, responsive and accessible maternity services. New and different types of care will be developed and designed to meet the needs of all women; but particularly those women and families who need additional support. We also believe that increasing choice will improve the safety, quality and family-friendliness of maternity services and encourage good services to improve even more.

Sadly, some of our most deprived communities have not always been well served in their maternity care. We want to change that. We want to ensure that the needs of these women, their partners and their families are treated with equal importance and respect.

This is an exciting time for taking forward a key part of the health reform agenda and we are confident that the priorities and pledges set out in this strategy will deliver improved outcomes for women and babies.

# 1. Executive summary

## National priorities

- 1.1 The aim of health reform in England is “to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest healthcare”<sup>1</sup>. For maternity services this means providing high quality, safe and accessible services that are both women-focused and family-centred.
- 1.2 In 2005, the Government underlined the importance of providing high quality, safe and accessible maternity care through its commitment to offer all women and their partners, a wider choice of type and place of maternity care and birth. The NSF<sup>2</sup> for Children, Young People and Maternity Services acknowledges the importance of addressing the needs of women and their partners before the woman becomes pregnant, throughout pregnancy and childbirth and as they embark on parenthood and family life. The wider agenda for children and young people as outlined in *Every Child Matters: Change for Children*<sup>3</sup> and as specified in the NSF, states what women can expect during pregnancy.

## The vision

- 1.3 The vision is to achieve first class care across the whole maternity pathway in East Sussex through the development and delivery of a modernised, women-focused and family-centred maternity service. This document sets out a three year improvement strategy with much of the detail relating to “how we will achieve our strategy” being contained in the Maternity Strategy Action Plan. The service commitments, service priorities, proposed model, commissioning and performance monitoring arrangements are set out in the main document.
- 1.4 ***The Maternity Services Strategy*** sets out a comprehensive programme for improving choice, access and continuity of care, putting women and their partners at the centre of their local maternity service provision. It highlights how commissioners, providers and teams of maternity care professionals will be able to use the health reform agenda to shape the provision of services to meet the needs of women and their families. It emphasises the roles that each can play in providing women-focused, family-centred services and gives examples of what could be in place to achieve this. The key aim is to improve the quality of service, safety, outcomes and satisfaction for all women through offering informed choice around the type of care that they receive, and improved access to services whilst ensuring continuity of care and support. This strategy also sets out a number of commitments and measures towards

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<sup>1</sup> Department of Health, Health Reform in England: update and commissioning framework (2006)

<sup>2</sup> Department of Health National Services Framework for Children, Young People and Maternity Services (2004)

<sup>3</sup> Department for Education and Skills Every Child Matters: Change for Children (2004)

*Making Normal Birth a Reality*<sup>4</sup> whilst respecting women's individual needs and wishes.

### **Healthier people, Excellent care**

- 1.5 The strategy aims to achieve the pledges relating to maternity and the newborn set out in the South East Coast Strategic Health Authority vision, ***Healthier People, Excellent Care***<sup>5</sup>
- By 2011 90% of pregnant women will see a midwife within 12 weeks of confirmation of pregnancy to discuss their individual needs and preferences about how and where to give birth. We will focus in particular on making contact with women from vulnerable groups
  - By 2010 every woman will be able to make an informed choice about place of birth in the knowledge that the NHS will be able to meet her preference for a home birth, birth in midwife led unit, or birth in a consultant led unit
  - By 2010 there will be a consultant present for at least 60 hours of every week on the labour ward in every consultant led obstetric unit (with the exception of units with fewer than 2500 births a year where 40 hours will be the minimum).
  - By 2010 all women will be individually supported by a midwife throughout their labour and birth following confirmation of established labour
  - By 2010 we will ensure that all mothers and babies receive high quality postnatal care, for example support with breastfeeding for at least 6 weeks.
  - By 2011 all pregnant women and new mothers will be able to get the help they need with mental health problems.

### **The national choice guarantees**

- 1.6 Building on this vision the strategy sets out how we will promote and achieve the four national choice guarantees to ensure that women and their partners have opportunities to make well-informed decisions about their care throughout pregnancy, birth and postnatally. The national choice guarantees described in this document are:

1. **Choice of how to access maternity care**
2. **Choice of type of antenatal care**
3. **Choice of place of birth** – Depending on their circumstances, women and their partners will be able to choose between three different options. These are:
  - a home birth
  - birth in a local facility, including a hospital, under the care of a midwife

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<sup>4</sup> Making Normal Birth A Reality, Maternity Care Working Party, November 2007

<sup>5</sup> Healthier people, Excellent Care, SEC SHA, 2008

- birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option

#### 4. Choice of place of postnatal care

- 1.7 As well as the choice of local options, a woman may choose to access maternity services outside her area with a provider that has available capacity. In addition, every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth.

#### Local challenges

- 1.8 For some, especially the more vulnerable and disadvantaged, the outcomes at present are unacceptable. Some women are up to 20 times more likely to die from a pregnancy-related complication than others. Infant mortality rates are higher in more deprived areas of the country and in more vulnerable or disadvantaged groups<sup>6</sup>.
- 1.9 Future maternity services must be planned to address current challenges including improving outcomes for more vulnerable and disadvantaged families, the reduction in working hours of doctors as a result of the European Working Time Directive (EWTD)<sup>7</sup> and demographic and lifestyle changes. At the same time, the principle should be that pregnancy and birth are normal life events supported by midwives.
- 1.10 The PCTs' recognise the many challenges they face in implementing the health reform agenda. However, we are enthusiastic about realising the potential benefits and outcomes associated with the opportunities for improvements and innovation.

#### Clear planning framework

- 1.11 This strategy is unique in bringing together both the action plan arising from the IRP recommendations and the Maternity Matters Action Plan into a single Maternity Strategy Action Plan. There will be a direct link between the corporate performance management framework, Maternity Dashboard and action plan maintaining the golden thread and ensuring that targets are both realistic and achievable.
- 1.12 This strategy sets out the PCT's plans in relation to:
- delivering high quality and safe services, provided within the context of national standards.
  - ensuring an appropriately-skilled maternity workforce with regular continuing professional development is in place.
  - establishing an effective local commissioning framework.
  - ensuring tariffs support the effective commissioning of high quality and innovative services.

<sup>6</sup> Lewis G. Confidential Enquiries into Maternal and Child Health. Why Mothers Die. The Sixth Report of the United Kingdom Enquiries into maternal deaths 2000-2002 (2004)

<sup>7</sup> HSC, Guidance on implementing the European Working Time Directive for Doctors in Training, January 2003

- developing the monitoring framework for the future.
- delivering the national choice guarantee.

### **Consultation and engagement in the Strategy**

- 1.13 Initial development of this strategy was undertaken by the Maternity Strategy Working Group. This focus of this work was on the development of antenatal, postnatal and community services and engagement with stakeholders and partners formed part of this.
- 1.14 The Maternity Services Liaison Committee (MSLC) has a key role to play in taking forward the maternity strategy. As the PCT are now responsible for hosting the MSLC a review of arrangements will be undertaken to ensure that the committee is set up in the best way possible to support members in effectively engaging with service providers and commissioners. This will include ensuring that the recommendations of Towards Better Births<sup>8</sup> are met.
- 1.15 A central part of the work completed by the MSDP was to establish robust stakeholder engagement in taking forward local maternity plans. A maternity engagement plan was developed by the MSDP and its implementation monitored through a Maternity Services Patient Reference Group (MSPRG), made up of local stakeholders. The outcomes from this work have directly informed the development of the maternity strategy and the action plan.

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<sup>8</sup> Healthcare Commission, Towards better births, A Review of Maternity Services in England, July 2008.

## 2 Introduction and background

### Policy context

- 2.1 The NSF for Children, Young People and Maternity Services acknowledges the importance of addressing the needs of women and their partners before the woman becomes pregnant, throughout pregnancy and childbirth and as they embark on parenthood and family life. The wider agenda for children and young people as outlined in *Every Child Matters: Change for Children* and as specified in the NSF, states what women can expect during pregnancy. The overarching maternity standard for the NSF is that:

*Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies*

- 2.2 Maternity Matters<sup>9</sup> describes a comprehensive programme for improving choice, access and continuity of care and sets out a strategy to put women and their partners at the centre of their local maternity service provision. Its key aim is to improve the quality of service, safety, outcomes and satisfaction for all women through offering informed choice around the type of care that they receive, and improved access to services whilst ensuring continuity of care and support.

### Our priorities and commitments

- 2.3 The PCTs are committed to implementing Maternity Matters through the development and delivery of flexible, accessible individualised services designed to fit around the woman and her baby. Services will be women-focused, family-centred and accessible to all - designed to take full account of individual needs, including different language, cultural, religious and social needs or particular needs related to disability, including learning disability.
- 2.4 This is a three year improvement strategy; its purpose and scope is to achieve first class care across the whole maternity pathway, taking account of political, environmental, social and technological factors, and an assessment of current strengths, weaknesses, opportunities and threats.
- 2.5 Following a period of consultation and publication of the IRP recommendations for maternity services the PCT Boards agreed to the full implementation of the recommendations, incorporating the development of a robust maternity strategy covering the whole pathway of care. The IRP published its report on the proposed changes to maternity, gynaecology and special care baby care services in East Sussex on September 4<sup>th</sup> 2008. The report made clear recommendations for ensuring the delivery of safe, sustainable services in East Sussex.

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<sup>9</sup> DOH, Maternity Matters, choice, access and continuity of care in a safe service, April 2007.

## **Governance arrangements**

2.6 The MSDP has been set up as a project board to drive forward the implementation of the IRP recommendations on behalf of the Joint Committee of the PCT Boards. The priorities that will be taken forward within the life of this strategy will therefore include:

- Develop a model of care that ensures the continuation of consultant-led maternity services, special care baby services and inpatient gynaecology services in both Hastings and Eastbourne.
- Ensure that improvements to antenatal and postnatal care and associated outreach services are implemented without delay.
- Develop further community outreach services, which will include health visiting and community midwifery, and ensure that these services are staffed accordingly.'
- Develop a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the IRP recommendations.
- Reduce inequalities, responding to the Health Impact Assessment.
- Set out the way in which the East Sussex health community will implement Maternity Matters, and ensure that the four national choice guarantees are met in East Sussex.

## **The four national choice guarantees**

2.7 A central part of the strategy will be taking forward our commitment to the four national choice guarantees, so that by the end of 2009 all women and their partners will have:

- **Choice of how to access maternity care**
- **Choice of type of antenatal care**
- **Choice of place of birth** – Depending on their circumstances, women and their partners will be able to choose between three different options. These are:
  - a home birth
  - birth in a local facility, including a hospital, under the care of a midwife
  - birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option
- **Choice of place of postnatal care**

## **High quality, safe and accessible services**

2.8 To enable the provision of high quality, safe and accessible services we will work to ensure that:

- all women will have choice in where and how they have their baby and what pain relief to use, depending on their individual circumstances.
- support is linked closely to other services provided in the community, such as in Sure Start Children's Centres, to improve accessibility and promote early integration with other services.
- every woman is supported by a midwife she knows and trusts throughout her pregnancy and afterwards so as to provide continuity of care.

### **Wider policy context**

2.9 Maternity care provides a unique opportunity for health care professionals to meet and support women, partners and their families who might otherwise never, or rarely, access health services. We recognize the wider role that maternity services have to play in contributing to the achievement of the *Department of Health's (DH) Public Service Agreement (PSA) targets*<sup>10</sup> including:

- **The review of the Health Inequalities Infant Mortality PSA target** to substantially reduce mortality rates by 2010 (and the wider recommended actions that support the achievement of national targets).
- **Smoking cessation target:** to deliver a 1% point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups.
- **Breastfeeding:** to deliver an increase of 2% points per year in the breastfeeding initiation rate, focusing especially on women from disadvantaged groups.

2.10 The wider policy issues that have directly influenced and shaped the priorities in this strategy include:

- ***Making normal birth a reality* (The Maternity Care Working Party, 2007 endorsed by RCOG, RCM and NCT):** advocates normal births with a minimum of medical procedures and interventions, provided the baby is safe and the woman feels she can cope. We support the range of measures that are set out in this paper towards an increased normal birth rate whilst respecting women's individual needs and wishes.
- ***Healthier People Excellent Care* (NHS South East Coast, 2008)** the outcome of a review of maternity and newborn care in the context of the Next Stage Review led by Lord Darzi. We support the recommendations within the review and have incorporated a number of the targets into this strategy.
- ***Safer Childbirth* (Royal College of Obstetricians and Gynaecologists, 2007):** We support the development of a comprehensive single set of standards covering the full maternity care pathway to be used by commissioners, providers and healthcare professionals.
- ***Towards Better Births* (Healthcare Commission, 2008):** Reports on investigations carried out at individual trusts in relation to maternity

<sup>10</sup> HM Treasury 2004 Spending Review: Public Service Agreements 2005-2008 (2004)

services and the outcomes from a national survey of 26,000 women. Many of the national challenges also reflect local issues and priorities that are addressed within this strategy.

- ***Saving Mother's Lives (Confidential Enquiry into Maternal and Child Health, 2007)***: reviews all maternal deaths in the UK between 2003 and 2005. The review found that maternal deaths are not falling and cites a number of possible reasons. One key outcome is the link between adverse pregnancy outcomes and vulnerability and social exclusion with the report indicating that those who need maternity services most use them the least. Another significant outcome from the review was the production of a "top ten" list of recommendations for all providers and commissioners of maternity services. The Joint Committee of the two East Sussex PCT's committed to their full implementation at a meeting on 20<sup>th</sup> December 2007.
- ***Perinatal Mortality 2006 (CEMACH, 2008)***: This report found that maternal age, obesity, social deprivation and ethnicity are important factors for perinatal mortality.
- ***Safe Births: Everybody's Business (Kings Fund, 2008)***: This report identified a number of actions that were necessary for improving safety covering maternity teams, staffing, training, information and guidance, roles and responsibilities. The PCTs will have regard for safety and issues during the development of sustainable maternity services.

### **Local needs**

- 2.11 The *Healthcare Commission National Survey of Women's Experiences (2007)* found that 80% were pleased with the care they received when they had their baby but would have preferred more choice about the type of care and about where to have their baby. Although many already receive this choice, the priority for modern maternity services is to provide a choice of safe, high quality maternity care for all women and their partners. This is to ensure pregnancy and birth are as safe and satisfying as possible for both mother and baby and to support new parents, including single parent families and same-sex couples, to have a confident start to family life.
- 2.12 Locally, views have been gathered from a number of sources including a focus group of young mothers convened in support of the *South East Coast Pathway Review for Maternity and the Newborn Stakeholder Review*. Wider views were also gathered through the East Sussex Fit for the Future consultation largely linked to the configuration of hospital services. Key findings from the consultation are as follows:

- **Ante natal care**
- In East Sussex 84% of women reported that the health professional they saw first when pregnant was their GP. This compares to 78% nationally. This will have implications when looking at ensuring women are assessed before 12 weeks. Direct access to midwives may have a limited impact. Ensuring GP to midwife referrals are timely and effective is likely to remain very important. In addition, 36% reported seeing a GP for at least one antenatal check-up.
- 96% of East Sussex women were able to see the healthcare professional of their choice as soon as they wanted, slightly above the national average.
- 36% of East Sussex women were given a choice of where they could have their antenatal check-ups which compares well with the national picture.
- Only 13% of East Sussex women were given a choice about who would carry out the antenatal check-ups, suggesting a significant challenge in this area.
- 27% of East Sussex women reported seeing the same midwife for antenatal checks every time and 46% saw the same midwife most of the time.
- Encouragingly, 94% reported that during their pregnancy they had the name and telephone number of a midwife they could contact if worried – another element of continuity of care in maternity matters.
- 90% of East Sussex women (compared with 81% nationally) reported being offered a choice of where they could have the baby, and many of the remaining 10% were not given a choice for medical reasons. However only 53% reported that they got enough information from a midwife or doctor to help them decide where to have their baby. This is close to national norms but clearly still of great concern.
- Women said they saw too many midwives (and doctors). One consequence was having to repeat the same information on many occasions.
- **Promoting normal births**
- Women rated not being left alone during labour as a particularly important improvement.
- Some health professionals and voluntary groups felt that a greater focus on midwifery-led care could help to promote straightforward birth and facilitate choice. Councils also suggested that there was an opportunity to examine how health and social care services could work together to improve care around the time of birth, and that the PCTs should take a holistic approach to planning and implementation.
- The main perceived advantages of the PCTs' vision for the future, among both organisations and individuals were the potential to promote straightforward birth and the potential to increase midwife-led services such as Crowborough Birthing Centre.

- **Post natal care**
- 74% of East Sussex women reported that they had discussed breast feeding during pregnancy. While close to the national average, this should be an area for attention as we seek to increase sustained breastfeeding rates.
- In the six weeks after the birth, only 7% of women did not feel that they received help and advice from health professionals about feeding their baby.
- People felt that there was a lack of postnatal care, and that women were often discharged before they felt ready. They said that they perhaps needed more time to adjust to the baby and should be given more information about what to expect afterwards. They also wanted to see support for fathers.
- People were eager for levels of deprivation to be considered in future planning, as well as the impact that changes may have on local families, staff, and the environment.

### **Key challenges**

2.13 There are challenges that need to be addressed to achieve the commitments outlined in this strategy, as follows:

#### **Infant mortality<sup>11</sup>**

- 2.14 Women living in families where both partners were unemployed, many of whom had features of social exclusion, were up to 20 times more likely to die than women from the more advantaged groups.
- 2.15 Single mothers were three times more likely to die than those in stable relationships. Women living in the most deprived areas of England had a 45% higher death rate compared to women living in more affluent areas.
- 2.16 It is estimated 30% of domestic violence cases start or escalate during pregnancy and domestic violence is associated with increases in rates of miscarriage, low birth weight, premature birth, fetal injury and fetal death.
- 2.17 Higher than average death rates occur among babies born among black and minority ethnic populations, the babies of teenage mothers and those registered at birth by one parent rather than both.
- 2.18 Babies born in the most deprived areas of the country are up to six times more likely to die in infancy.

<sup>11</sup> Confidential Enquiries into Maternal and Child Health. Why Mothers Die. The Sixth Report of the United Kingdom Enquiries into maternal deaths 2000-2002 (2004)

## Impact of Deprivation on maternal and infant mortality

Stillbirth and neonatal mortality rates in England in 2005 for mothers resident in most deprived areas were 1.8 and 2.2 times higher when compared with rates in least deprived area

	Live births		Stillbirths			Neonatal deaths		
	Number	Rate*	Rate ratio ***	[95% CI]	Number	Rate**	Rate ratio ***	[95% CI]
Total	607,090	3,064	-	-	1,726	-	-	-
1 (least deprived)	167,684	345	3.5	-	171	1.7	-	-
2	129,918	421	4.2	1.2 [1, 1.4]	224	2.2	1.3 [1.1, 1.6]	
3	109,868	531	4.8	1.4 [1.2, 1.6]	277	2.5	1.5 [1.2, 1.8]	
4	100,815	714	5.5	1.6 [1.4, 1.8]	404	3.1	1.8 [1.5, 2.2]	
5 (most deprived)	98,805	1,040	6.2	1.8 [1.6, 2]	640	3.8	2.2 [1.9, 2.6]	

\* Rate per 1,000 total births

\*\* Rate per 1,000 live births

\*\*\* Rate ratio using least deprived as baseline

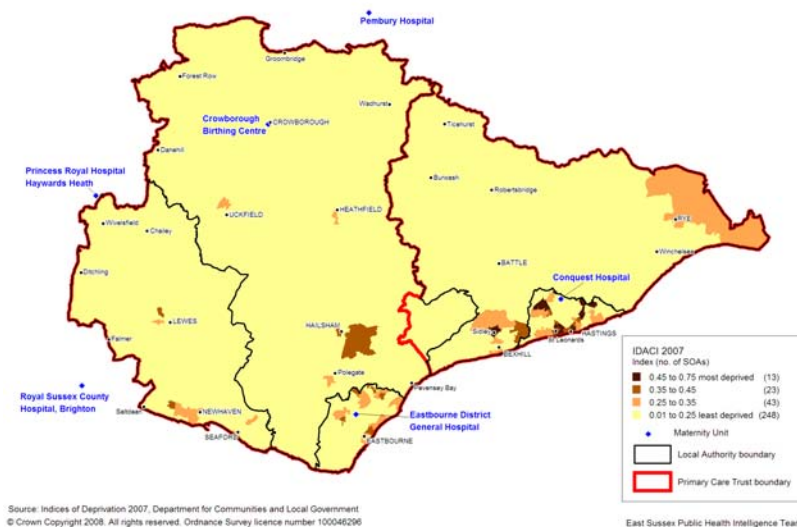
Source: Perinatal mortality 2005, CEMACH, April 2007

### Income deprivation

- 2.19 East Sussex is considered to be part of the affluent South East. However, this is misleading. Pay levels are about two-thirds of those in the rest of the South East. There are pockets of deprivation across the county, notably Hailsham, Eastbourne, Sidley and Newhaven, but deprivation most significantly affects the residents of Hastings. Hastings is the most deprived local authority in the South East.
- 2.20 'East Sussex in Figures'<sup>12</sup> reports that 13 small areas in East Sussex (technically referred to as 'Super Output Areas') were in the 10% most disadvantaged areas in England, 12 of these are in Hastings. Altogether just over one-third of all the Super Output Areas in Hastings are among the 20% most disadvantaged in England: the borough has the most disadvantaged Super Output Areas of any area in the south east.

<sup>12</sup> East Sussex in Figures, <http://www.eastsussexinfigures.org.uk/webview/>

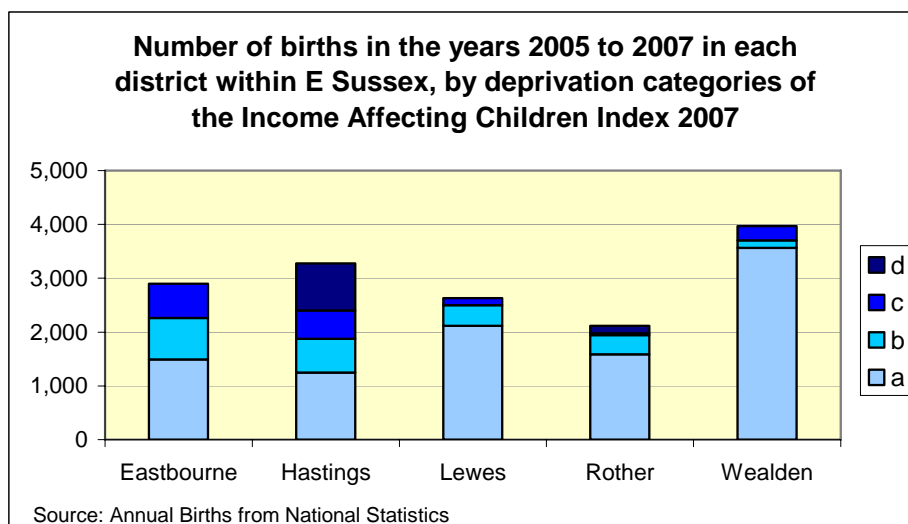
Income Deprivation Affecting Children Index (IDACI) 2007 by Super Output Area (SOA) in East Sussex



2.21 The Maternity Needs Assessment<sup>13</sup> carried out by Public Health on behalf of the Boards during consultation showed that five times as many babies in the most deprived areas were born in Hastings and Rother (Conquest catchment) compared with Eastbourne and Wealden South (Eastbourne District General Hospital catchment) and that four times as many deprived women of child bearing age are resident in the Conquest catchment area compared with EDGH.

2.22 The needs assessment also showed that people experiencing the highest levels of unemployment with no vocational or professional qualifications lived in Hastings and St Leonards.

<sup>13</sup> East Sussex Downs and Weald PCT, Maternity Services for East Sussex: Epidemiological Needs Assessment, Public Health



2.23 Access to a car or van can be directly important in accessing maternity care. A higher proportion of households with children without access to a car or van were seen in the urban districts, with the greatest proportion and number of households in Hastings.

### **Pregnancy in the under 18's**

2.24 Around 16% of all pregnant women, including many of those under 18 years of age, delay seeking maternity care until they are five or more months pregnant, thus missing the crucial early days of maternity care. These women and their babies have worse outcomes than those who access maternity care at an earlier stage of their pregnancy.

2.25 Commissioners need to understand what, in their current services, prevents these women from seeking care early or maintaining contact with maternity services and to overcome these barriers by providing more flexible services at times and places that meet the needs of these women.

2.26 Markers of deprivation are also reflected in indices considered to reflect social complexity, such as teenage mothers, obesity, smoking in pregnancy and late booking, all of which are more common amongst the population using the Conquest than amongst the population using the EDGH, and all of which would be expected to adversely affect outcomes for mother and baby.

2.27 For example, late bookings (after 12 weeks) were more common at the Conquest (28.2% vs. 22.5% in 2006/7) and teenage mothers aged 18 or under accounted for 7.6% of births at the Conquest compared to 5.4% at Eastbourne DGH.

### **Demographic and lifestyle challenges**

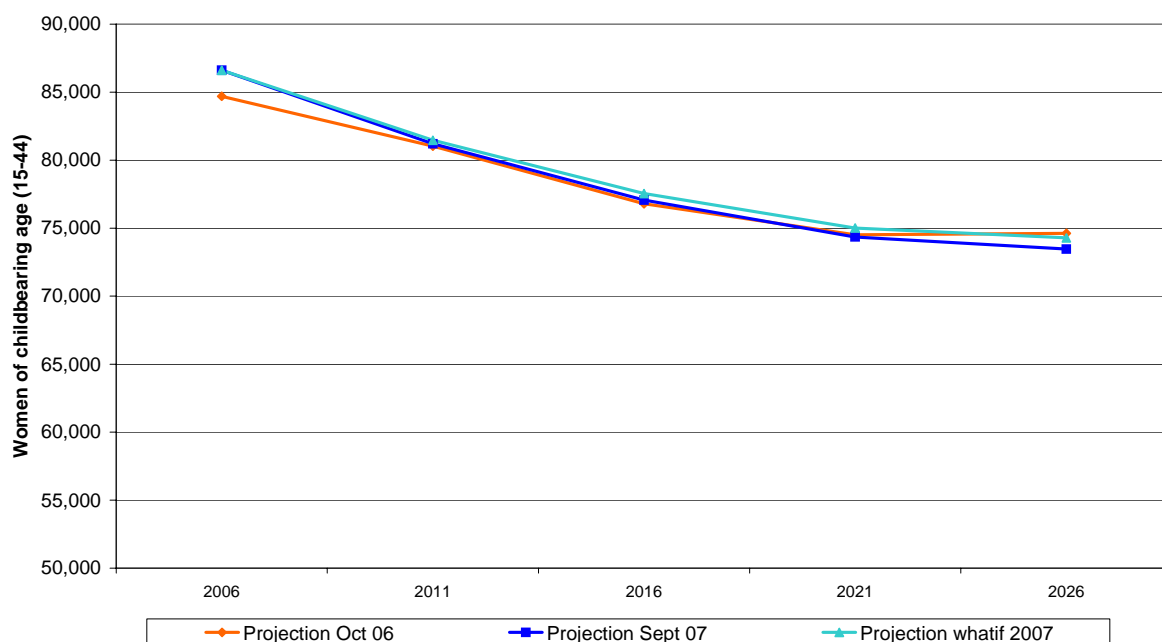
2.28 Demographic and lifestyle challenges need to be taken into account. These include a rising birth rate, more women having babies later in life and more assisted conception with a greater likelihood of multiple births.

2.29 An estimated 83, 800 women aged 15 to 44 lived in East Sussex in 2005, accounting for 17% of the population.

## Total population and women of child bearing age (15-44) by PCT and by District

Numbers of women of child bearing age by district				
PCT / Locality	Total Population	Females 15-44	%Total	
<b>East Sussex</b>	<b>497,900</b>	<b>83,800</b>	<b>17%</b>	
<b>East Sussex Downs &amp; Weald PCT</b>	327,300	55,400	17%	
Eastbourne B.C.	92,900	17,200	19%	
Wealden D.C.	141,000	22,800	16%	
Lewes D.C.	93,400	15,400	16%	
<b>Hastings &amp; Rother PCT</b>	170,600	28,300	17%	
Hastings B.C.	84,600	16,300	19%	
Rother D.C.	86,000	12,000	14%	
<i>Source: National Statistics Mid-year Estimates 2005</i>				

- 2.30 Population projections provided to the Boards during consultation, by S Boughton, Principal Planner (Demography and Housing), ESCC, suggested that over the twenty years to 2026, the number of women of child-bearing age is expected to decrease by 15%, from 86,600 to 73,500.
- 2.31 Projections were based on the latest 2006 mid-year estimate, and reflect the housing levels being planned for through the draft South East Plan and local development frameworks (taking account of the additional 80 dwellings per annum recommended by the South East Plan EIP Panel).



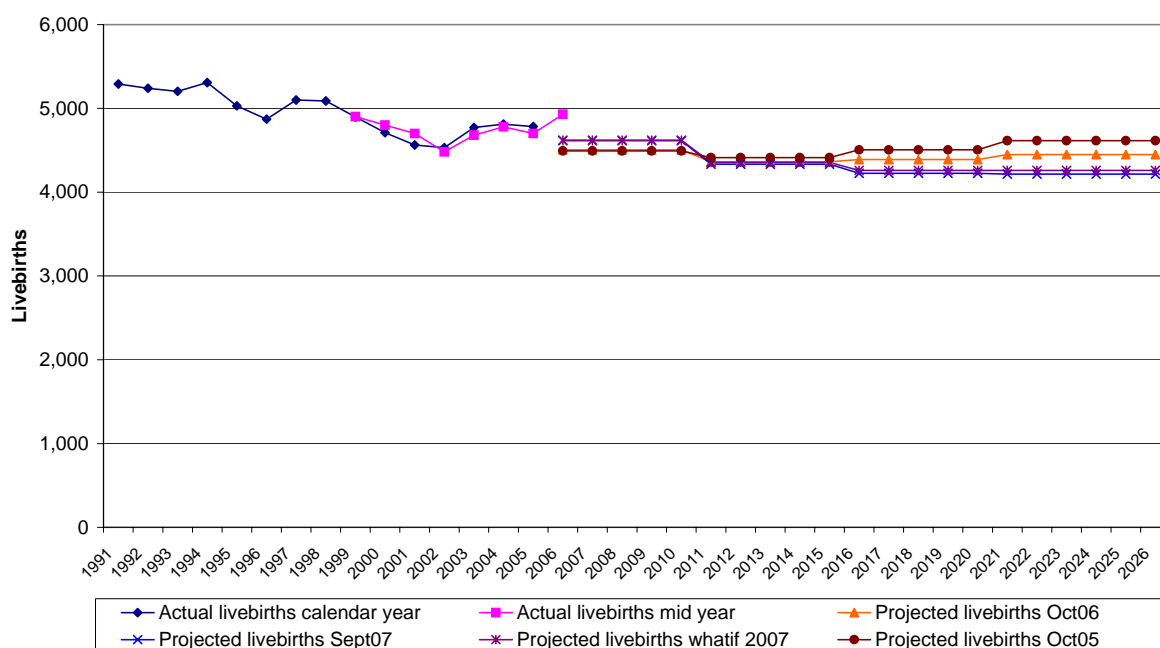
2.32 In understanding these projections it should be noted that overall population growth is expected to be 2.6% but this is mainly amongst older age groups (aged over 50). Households with a “head” over pensionable age are projected to increase by nearly 42% over the twenty years to 2026. Much higher growth in households or dwellings is projected (11.5%), but this reflects declining average household size, with one person households projected to increase by over a third by 2026, many of these in older age groups.

### **Births**

2.33 Births to women resident in East Sussex have fallen over the last 15 years from 5,300 per year in 1991 reaching a low in 2002, with a recent reversal of this trend, seeing births rising back towards 5,000 per year.

2.34 Average births over the period 2001-6 were used as a basis for calculating future births to 2026.

## Actual and projected births, 1991 – 2026



- 2.35 The effect of planned additional dwellings on numbers of births was considered as part of this process and found to have a very small impact (0.6%). The most recent September 2007 projections revised estimates of births and women of child bearing age in 2026 downwards, but noted the small but distinct upturn in very recent births.
- 2.36 Teenage mothers are three times more likely to smoke through their pregnancy than older mothers. Women from disadvantaged backgrounds may require additional services to meet their own particular needs. Each of these factors lead to an increase in the number of mothers and babies who may need more specialist medical care from obstetricians, anaesthetists, mental health practitioners, neonatologists or others, through maternity team care.

IDACI 2007	No Births 2003-2005				Total	% with birthweight below 2,500g					Total	No. with Low Birth weight 2005-2007				
	a	b	c	d		a	b	c	d	a		b	c	d	Total	
E SUSSEX	10,004	2,280	1,591	1,013	14,888	7%	9%	9%	12%	8%	677	196	144	123	1140	
Eastbourne	1,491	773	633		2,897	9%	10%	9%		9%	130	80	58		268	
Hastings	1,248	624	533	873	3,278	7%	9%	9%	12%	9%	92	57	49	105	303	
Lewes	2,116	383	128		2,627	5%	5%	9%		5%	103	20	11		134	
Rother	1,585	358	33	140	2,116	6%	8%	12%	13%	7%	103	28	4	18	153	
Wealden	3,564	142	264		3,970	7%	8%	8%		7%	249	11	22		282	

Note: Category a is the least deprived 76% of the area

Category b is the next 13% of the area

Category c is the next 7% of the area

And category d is the worst 4% of the area.

- 2.37 There are slightly more mothers over the age of forty and women from ethnic minorities booking at EDGH compared with Hastings.
- 2.38 The rate of low birth weight babies (below 2,500g) in Eastbourne, Wealden, and Rother is slightly below the England and Wales average, whereas the rates in Hastings are slightly above the England and Wales average.

### **Introduction of the European Working Time Directive (EWTB)/level of specialisation**

- 2.39 The introduction of the EWTB has resulted in a reduction in doctors' hours contributing to a requirement for different ways of working to provide maternity care. Modernising Medical Careers<sup>14</sup> recognises these challenges and proposes a major reform of postgraduate medical education that aims to improve patient care by delivering a modernised and focused career structure for doctors. The emphasis is on effective recruitment, good induction and supportive management, the development of shared service models, effective use of IT, job and service re-design and effective training/development.
- 2.40 Maternity team care and more specialised services may need to be concentrated in fewer, more comprehensive facilities and will be informed by the development of the network model. At the same time, midwifery services are being strengthened in community settings for women with straightforward, low risk pregnancies.

### **Pregnancy as a normal life event**

- 2.41 We recognise that pregnancy and birth are normal life events for most women. However, when specialist care is required, we believe it must be readily available and of the highest possible quality. This means ensuring that all women have access to their midwife in their local community and, should it be required, can have immediate transfer to a fully equipped local hospital with obstetricians, anaesthetists and other specialists in maternity or newborn care to provide a safe round the clock service that meets national standards.
- 2.42 All midwives require the skills and up to date knowledge to know whom to refer to as well as when and how to refer for more specialist opinion and care. Practice must be based on available evidence and according to relevant clinical guidelines.

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<sup>14</sup> DOH, Modernising Medical Careers: the next steps, April 2004.

## 3 Current provision “the core maternity offer”

### The national choice guarantees

3.1 In this section the PCT's set out their commitment to implementing the four national choice guarantees which will be available to all women and their partners. These guarantees will provide women and their partners with the opportunity to make informed choices throughout pregnancy and birth and during the post natal period.

- **Choice of how to access maternity care** – When they first learn that they are pregnant, women and their partners will be able to go straight to a midwife if they wish, or to their General Practitioner. Self-referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services.
- **Choice of type of antenatal care** – Depending on their circumstances, women and their partners will be able to choose between midwifery care or care provided by a team of maternity health professionals including midwives and obstetricians. For some women, team care will be the safest option.
- **Choice of place of birth** – Depending on their circumstances, women and their partners will be able to choose where they wish to give birth. In making their decision, women will need to understand that their choice of place of birth will affect the choice of pain relief available to them. For example, epidural anaesthesia will only be available in hospitals where there is a 24 hour obstetric anaesthetic service.
- **Choice of place of postnatal care:** After going home, women and their partners will have a choice of how and where to access postnatal care. This will be provided either at home or in a community setting, such as a Sure Start Children's Centre.

### Access and continuity of care

#### Current provision, the service model

3.2 One of the key outcomes from the work undertaken by the MSDP in response to the IRP recommendations was to arrive at agreement across all stakeholder groups on an effective local maternity services model. As part of this work the MSDP established a Clinicians Forum made up of clinicians and stakeholders who in turn formed a number of clinical sub groups. Four clinical sub groups including midwifery and primary care, neonatal, anaesthetics and obstetric, gynaecological consultants met three- four times between April and July 09. The scope of their brief included a review of practice against national standards, current ways of working and areas for service improvement and development. A workforce, training and education sub group examined the workforce implications of recommendations and this has informed the development of a workforce plan that supports the implementation of the maternity strategy.

- 3.3 The outcomes of the work completed by each clinical sub group were summarised in a service proposal with a set of recommendations for presentation to a special Clinicians Forum Open Event, convened at the beginning of September 09. The purpose of the event was to pull together the work of each sub group into one final proposal/service model and to achieve sign up and vision towards the priorities for maternity services across East Sussex. Further input and up to date thinking in relation to maternity developments were also shared incorporating current thinking in relation to Quality Innovation and Productivity initiatives and the current commissioning environment.
- 3.4 One of the recommendations within the final paper, from the Clinicians Forum was for the MSDP to note that consultant led maternity services, incorporating special care baby and gynaecological services are and will continue to be delivered across two acute sites. A description of current core maternity services (the model) was agreed as follows:
- 3.5 East Sussex hospitals NHS Trust provides maternity care for approximately 5000 women living within the large geographical area of East Sussex and across the boundaries into Kent and West Sussex. There are around 4000 births annually and 88% of women give birth within the acute setting. 5% at home (4% planned home births; 1% unplanned) and 7% at Crowbrough Birthing Centre<sup>15</sup>.

***Early Pregnancy Care:***

- 3.6 Early pregnancy services are offered on both acute sites however these are facilitated in slightly different ways. Midwives facilitate a drop-in (with GP referral) clinic in the main Women's Health Outpatient area, from 8-9am seven days per week on the Eastbourne site. Ultrasound scanning is available and the clinic runs until the work is completed. In Hastings the service is supported by gynaecology nurse practitioner/Sonographer. The clinic runs Monday-Friday 0800-1500hrs on an appointment basis however, emergency referrals are accommodated as required.

***Antenatal Care:***

- 3.7 Antenatal care is available in GP surgeries, Children's Centres, Health Centers, DGH Hospitals and sometimes at home. The service is integrated and makes effective use of professional roles with midwives taking responsibility for normal pregnancy, referring to Obstetricians only if there are medical problems or if a woman chooses. Midwives order routine scanning, pathology and haematology investigations, and have direct referral to Consultant Obstetrician for advice.

***Antenatal Appointments – Acute Setting:***

- 3.8 Antenatal clinic at Eastbourne DGH, is part of the main Women's Health Clinic. There are currently two antenatal clinics for 'high risk women'. Ultrasound scanning facilities are available alongside the clinic and often women have scan appointments booked for the same time.

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<sup>15</sup> Obtained from annual figures provided by Euroking Maternity Database – 2007/08

- 3.9 Weekly antenatal clinics are held on the Hastings site; three based on the maternity unit and one in the main outpatient department alongside ultrasound scanning facilities. A key feature within this strategy is to ensure the provision of more flexible times and venues for antenatal and postnatal care.

***Parent Preparation Sessions:***

- 3.10 Women giving birth in East Sussex have access to free parent education sessions, facilitated mainly by midwives with occasional additional input from other professionals. These sessions are offered from approximately 32 weeks gestation and are open to mothers and their birth partners and are provided in various locations within the community and acute unit. Times, venues and the number of sessions offered are varied<sup>16</sup> and although other agencies within the localities offer parent preparation sessions, there is a substantial fee to access these.
- 3.11 The provision of equitable, easily accessible parent preparation sessions focusing normality, including information about practical skills for coping with labour and childbirth has been explored and the NCT have been approached to provide such classes.

***Intrapartum Care:***

- 3.12 Generally women are given verbal and written information about options for birth.
- 3.13 Within the acute setting at Eastbourne DGH, there are 6 birthing rooms, a water birth room, a recovery/high dependency area with two beds and two single rooms with en-suite facilities (one of these is used for bereaved parents). There is a dedicated operating theatre. In comparison, Hastings has 7 birthing rooms all with en suite facilities, one of which is used for water birth. In addition, there is a room for bereaved parents. A 24 hour duty anaesthetist provides and epidural service on both acute sites.
- 3.14 Crowborough Birthing Centre (CBC) is a midwife-led unit and undertakes approximately 300 births per year. It provides women with 24 hour access to a 'home from home' environment and consists of 6 postnatal beds and 2 birthing rooms.

***Postnatal Care:***

- 3.15 Postnatal wards are made up of four-bedded bays and single rooms. Eastbourne has 16 postnatal beds and four single en suite rooms at the present time. Beds are used according to need and one of the single rooms has been adapted for women with disabilities. Frankshaw ward, on the Hastings site, comprises 12 postnatal beds and two single en suite rooms. As with Eastbourne, beds are used according to need and the side rooms offered as amenity. All beds have 'Patient line' system, which enables

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<sup>16</sup> Information obtained from a benchmark of current maternity service provision – parent preparation audit - 2008

women to use the phone, listen to the radio or watch television at their bedside.

- 3.16 In addition there are 8 antenatal beds at Eastbourne DGH and 6 Antenatal beds at The Conquest, Hastings that can be used as additional post natal facilities if required.
- 3.17 Postnatal care is largely shared between hospital and community midwifery staff. Once care of the woman is transferred to the community midwife women are seen at home between the hours of 9am-5pm. Visits are tailored to meet individual need and this care continues until around the 10<sup>th</sup> postnatal day when care is transferred to the health visiting team. A formal handover of care from the midwife to the health visitor does not routinely take place for all women. However, those women with complex issues are usually discussed between the midwife and the health visitor taking over the woman's care<sup>3</sup>.
- 3.18 A small proportion of women are seen by the Obstetrician for postnatal medical follow-up, if required, the majority are seen by their General Practitioner.

#### **Consultant care (obstetrics and gynaecology)**

- 3.19 There were 4133 births in ESHT during 2008, with approximately 88% of births taking place in the acute setting. The remaining births took place at Crowborough birth centre or at home. The number of women booked for consultant care accounted for 1428 (804 CQQ: 5 CBC: 619 EDGH). In addition, a further 718 women were transferred from midwifery led care, to the care of a Consultant at some point during their pregnancy/labour.
- 3.20 The normal birth rate was 67.41%; the induction rate for the Trust during 2008/09 was 19.55%; elective caesarean section rate was 8.44% and the emergency caesarean section rate was 12.23% (total c/section rate was therefore 20.77%).
- 3.21 Each site provides outpatient access to Obstetric, Gynaecology and specialist interest clinics. A further outpatient clinic at Crowborough birthing centre is provided on a monthly basis.
- 3.22 The obstetric team comprises:
- 10 Obstetric Consultants working within the acute setting at ESHT (5 on the Eastbourne site and 5 on the Hastings site).
  - 12 doctors on the Eastbourne site at various stages of their training. This comprises 1 Associate Specialist, 3x staff grades, and 8 additional trainees. One of the junior training posts is vacant
  - Hastings - 12 doctors at various stages of training. 1 Associate Specialist, 4x staff grades, one trust registrar and 2 Specialty registrars. The remaining 4 are made up of junior trainees and GP trainees, of these two posts are vacant (ESHT Staff List, August 2009).
- 3.23 Consultant job plans comprise Obstetric and Gynaecology commitments including theatre sessions, general gynaecology clinics, antenatal clinics, special interest development, caesarean section and labour ward sessions,

out of hours on call cover . Each Consultant's job plan includes 8.5 PAS for direct clinical care: this includes 2 PAs for out of hours on call cover (each PA being 4 hours in duration). There is also an allocation of 2.5 SPAs in each consultants job plan to include activities such as Labour ward lead, risk management lead, College Tutor, audit, training, CPD etc.

- 3.24 All Consultants undertake a specialist interest area and there are plans to develop these further.

***Special Care Baby Unit (SCBU):***

- 3.25 Both acute units have access to level 1 SCBU services, EDGH has 7 cots; The Conquest 6. Both units have parent's accommodation. The units are very busy and rarely have empty cots. Babies requiring level 2 or 3 care are transferred to a unit where a cot is available, this is coordinated by the emergency bed/cot service.
- 3.26 There is also an antenatal/ postnatal mental health support group run by a Specialist health visitor/ and midwife who take referrals during pregnancy, visits to assess and then, if appropriate, brings the woman into a support group for a series of meetings. This group is available in Hastings and Rural area. It is aimed at women with depression to help overcome isolation, lift and motivate them to enable better parenting and establish links with the Children's Centres and other services
- 3.27 Although East Sussex is considered to be part of the affluent South East, pockets of deprivation exist across the county. These are most notably in Hailsham, Eastbourne, Sidley and Newhaven. However, the most significant area affected by social deprivation is Hastings. National evidence suggests that women living in disadvantaged or minority groups and communities are significantly less likely to access services early or maintain contact throughout their pregnancies. As a consequence, outcomes for their own and their babies' health and well-being are worse than for the population as a whole (DH, 2004<sup>17</sup>). Additional Support Midwives (ASM) provide enhanced midwifery services for those women requiring it. Additional support midwives are currently based in Hastings, St Leonards and Bexhill, there are vacant posts for Eastbourne and Hailsham.
- 3.28 An infant feeding specialist has been employed since April 2009 to drive forward the recommendation to improve Breastfeeding initiation and maintenance rates, assist mothers experiencing feeding problems (regardless of their chosen method of feeding) and to provide a division of tongue tie service.
- 3.29 In addition, an antenatal screening coordinator has also been employed to coordinate the combined screening program as recommended by the National Screening Committee. She also provides women with additional specialist information in relation to screening tests, coordinates referrals to tertiary units where necessary and provides additional support for women who receive negative results.

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<sup>17</sup> Department of Health. 2004. National Service Framework for Children, Young People and Maternity Services: Maternity Services. London: Department of Health

3.30 The British Association for Perinatal Medicine (BAPM) categorises neonatal care required by babies into intensive care, high dependency care, special care and normal care, with the last not normally provided in hospital.<sup>18</sup>

**Level 1 provision across both sites**

3.31 The SCBUs at Eastbourne DGH and the Conquest Hospital are both Level 1 Units. The Network guidelines advise that neither Unit should accept women for delivery who are < 32 weeks in gestation, unless transfer is impossible for clinical reasons, and to ask the local maternity team to transfer all such women who present in labour to a tertiary centre in good time. The BAPM definition of a designated Level 1 Unit is as follows:

*Units provide Special Care but do not aim to provide any continuing High Dependency or Intensive Care. This term includes Units with or without resident medical staff.*

3.32 However, BAPM guidelines also state that: “All maternity Units must provide facilities for the care of unexpectedly sick newborn infants.” The scope of these services and transfer requirements are set out in the guidelines and include:

- Incubator care
- Monitoring of vital signs, including blood pressure and blood gases
- Fluid and drug treatment
- Venous access
- Artificial ventilation
- Portable x-ray facilities
- Drainage of a pneumothorax
- Administration of Surfactant

3.32 All these services are available across both acute sites with access to a professional who is skilled in all aspects of neonatal resuscitation.

**Number of cot care days**

3.33 The level of care provided in Neonatal Units is usually expressed in cot days care. In 2008, Eastbourne DGH provided a total of 2182 cot days while the Conquest Hospital provided 1970 cot days. Types of care provided in 2008 are broken down as follows:

***SCBU activity at Eastbourne DGH and the Conquest Hospital, 2008***

	<b>Eastbourne DGH</b>	<b>Conquest Hospital</b>
No. Of cots	7	6
No. Of babies delivered	1993	1812

<sup>18</sup> See BAPM: Standards for Hospitals Providing Neonatal Intensive and High dependency Care (second edition) and Categories of Babies Requiring Neonatal Care (2001).

No. Of admissions <sup>19</sup>	251	174
Transfer out	33	34
Cot days ITU	37	74
Cot days HDU	139	112
Cot days SCBU	2006	1784
Total cot days	2182	1970
Average occupancy	78%	81%

3.34 Eastbourne DGH has 7 designated cots in its SCBU while the Conquest Hospital has 6. This is below the required levels, given the level of activity. To manage this activity more effectively would require an increase in Special Care cots. Ideally there should be at least eight SCBU cots in each Unit.

3.35 The average total cot occupancy during 2008, which excludes peaks in the number of admissions, was 78% at Eastbourne DGH and 81% at the Conquest Hospital. The BAPM recommends that cot occupancy should not exceed 70%. A figure above this is associated with increased risk and poorer outcome of patients.

#### **Transfer activity**

3.36 Both Neonatal Units have had a significant number of ex-utero transfers to tertiary centres for either medical or surgical treatment, during 2008. In both Eastbourne DGH and the Conquest Hospital, pregnant women less than 32 completed weeks gestation who present in early labour are usually transferred in-utero to tertiary centres by the maternity service to deliver there whenever possible. However, both Neonatal Units are staffed and equipped to deal with all premature or complicated deliveries if in-utero transfer is not possible; this includes resuscitation and stabilisation of the infant until the retrieval teams from tertiary centres arrive. These babies tend on the whole to be premature.

#### **Staffing levels**

3.37 The recommendations for staffing levels as set out in the BAPM guidelines are now regarded as minimum standards. For special care a nurse should not have responsibility for the care of more than four babies and for High Dependency Care a nurse should not have responsibility for the care of more than two babies. Units undertaking any neonatal intensive or high dependency care should have a senior nurse with neonatal experience and managerial responsibility.

3.38 At present the 6 cots in the Neonatal Unit at the Conquest Hospital are staffed with 2 qualified nurses per 12 hours shift. The nursery nurses or at times a trained member of staff make up the 3<sup>rd</sup> member of staff for some of the day shifts but none of the night shifts. At EDGH the Unit has 7 cots and currently

staffing levels are essentially the same as at the Conquest Hospital except that they have no nursery nurses to make up the third person on the day shift. In order to meet these levels EDGH will require a small uplift in the trained staff establishment when using the DH equation by 1.51 WTE for the additional 1 cot.

3.39 Professional nursing bodies reinforce the nurse staffing standards outlined by the British Association of Perinatal Medicine (BAPM)<sup>iii</sup>, with the ratio of registered nurse to infants varying according to defined clinical categories as cited below:

- *special care* 1:4
- *high dependency* 1:2
- *intensive care* 1:1.

3.40 While nursing establishments should be based on the level of clinical care each baby requires, The Royal College of Nursing (RCN) recommends that a 25 per cent time allowance should be incorporated in the overall establishments to allow for staff absences (sickness, annual leave and training and development)<sup>iii</sup> The DH in their report of an expert working Sub-Group on Neonatal Intensive Care Services also stated that there should also be additions for a shift co-ordinator with additions also being made for nurse practitioner or specialist nursing responsibilities such as infection control, professional leadership, education and training or community nursing support. At present however there is only an allowance of 21% on all nursing establishments within ESHT.

### **Medical staffing**

3.41 There are 5 acute consultant paediatricians on each site, with one consultant per site undertaking the role of lead in neonatology. All cover both the neonatal and the general paediatrics service.

3.42 There is no spare capacity to develop or enhance the service and an additional acute consultant paediatrician with a neonatal interest would be required in order to develop an enhanced Level 1/Level 2 service. This is to ensure there is sufficient capacity to maintain standards, to provide clinical leadership, to develop the service and to support and train staff. It is also necessary so that relationships with surrounding Units can be developed. It is essential that the additional consultant appointment is made before the service is developed.

3.43 There is adequate middle grade and SHO cover. All middle grade doctors have current validated certificates in neonatal resuscitation (either EPLS or NALS). The Neonatal Unit is covered by a separate middle grade and SHO rota during normal work hours. In relation to the out of hours cover, the on-call SHO and middle grade cover both neonatology and general paediatrics.

### **Anaesthetic care**

3.44 The normal birth rate (not using the accepted definition of 'Normal Delivery' from the Information Centre for the NHS in England (MCWP, 2007) was 67.41%; the induction rate for the Trust during 2008/09 was 19.55%; elective caesarean section rate was 8.44% and the emergency caesarean section rate was 12.23% (total c/section rate was therefore 20.77%). During 2008/09

25.6% of women received epidural/spinal analgesia for pain relief during labour and for birth. This compares favourably with the national average of 24% (OAA database, 2005).

- 3.45 Currently within ESHT maternity departments, women have access to a 24 hour epidural service provided by an on call anaesthetist. However, the duty anaesthetist is also on call for ITU and A & E and at times this impacts on the suggested target response time (currently set at 30 minutes) for obstetric calls.

### **Service priorities**

- 3.46 Priorities for action were identified by self-assessment against Maternity Matters standards and from the Healthcare Commission Review of Maternity Services 2007 (as set out in section 2 of this strategy). Those areas with the greatest scope for improvement compared to expected standards were considered priorities.
- 3.47 Maternity Matters Self-Assessment<sup>20</sup> was carried out by the Maternity Strategy Group using a nationally developed tool supporting Maternity Matters (with the local addition of those elements appearing in the NSF but not explicitly included in Maternity Matters). Items rated as red or amber/red were considered by the group to be priorities.
- 3.48 In the Healthcare Commission Review of Maternity Services 2007, East Sussex Hospitals scored 3.199 out of 5 overall, and was classified as a 'better performing' provider. Areas where ESHT scored less well (1 or 2 out of 5) were considered by the group to be priorities. The report of this work 'Towards Better Births' makes a series of recommendations. ESHT have undertaken a qualitative self-assessment against these recommendations and developed an action plan. This work has been taken into account in this strategy and more specifically the service priority table below.
- 3.49 The recent Maternity and Newborn Pathway Review across NHS South East Coast identified priorities for improvement. While there has not been a formal assessment of the appropriateness of these priorities for East Sussex, many clinicians from East Sussex were actively involved in the review, and the main recommendations of this work have therefore also been taken into account.
- 3.50 Many of the service priorities set out in the table below support the implementation of the IRP recommendations and are incorporated into the Maternity Strategy Action Plan (see Appendix A). The measures that the PCT's are taking towards implementing these choice guarantees are set out against our service priorities and expected outcomes.

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<sup>20</sup> DOH Maternity Matters Self Assessment Tool Kit for commissioners, 2007

## Service priorities, choice guarantees and expected outcomes

Choice/Service priority	Outcome
<p><b>Providing antenatal and postnatal care in convenient community settings, ideally Children's Centres), at times convenient to women and their families.</b></p>	<ul style="list-style-type: none"> <li>• Midwife-led antenatal and postnatal maternity services, co-located with health visiting and GP services to be provided at times convenient to women and their families.</li> <li>• Easily accessible clinics will be developed in GP surgeries as well as alternative local community settings (e.g. shopping centres). This is in line with the Maternity Matters vision for providing integrated maternity services in easily accessible and visible community settings such as Sure Start Children's Centres as a way to engage with the most vulnerable families.</li> </ul>
<p><b>Assessing each woman's needs and then providing care and support that meets those needs. This includes providing additional support for vulnerable women and their families.</b></p>	<ul style="list-style-type: none"> <li>• All women will have a personal care plan reflecting their needs and choices.</li> <li>• Universal antenatal care will follow the model recommended by National Institute for Health and Clinical Excellence (NICE).</li> <li>• Each woman's need for enhanced service will be assessed as part of the initial assessment.</li> <li>• A progressive (enhanced) maternity care model (over and above the universal service) will be offered to provide individually appropriate support for women and their babies and families with additional social or clinical needs.</li> </ul>
<p><b>Offering all women direct access to midwifery services</b></p>	<ul style="list-style-type: none"> <li>• Both antenatal and post-natal care will be directly accessible (i.e. without referral from a GP).</li> <li>• Systems to support direct access to midwives and self-referral will be developed and will facilitate access for some women who may be reluctant to see their GP.</li> <li>• By offering direct access to midwifery services ensure that all women have been assessed and provided with an individual care plan before 12 completed weeks of pregnancy.</li> <li>• Ensure that direct access is widely publicised and that all primary care staff can explain to service users how to directly access a midwife (e.g. in local pharmacies, GP receptionist, etc.).</li> <li>• Innovative approaches will be developed to get this information to women (for example including information in pregnancy test kits).</li> </ul>
<p><b>Ensuring early assessment for all pregnant women</b></p>	<ul style="list-style-type: none"> <li>• All women will have an initial assessment carried out by a maternity professional by 12 completed weeks of pregnancy. This is likely to require two appointments within this timescale, ideally with the first between 6 and 8 weeks gestation.</li> <li>• An evidence based assessment tool will be used (soon to</li> </ul>

Choice/Service priority	Outcome
	<p>be piloted by NICE).</p> <ul style="list-style-type: none"> <li>• Not all women will access midwives directly. Some will visit their GP, and from there be referred on for maternity care.</li> <li>• Referral processes will need to be reviewed to ensure that they are efficient and timely to facilitating early assessment.</li> <li>• Local data shows that in 2007/08 26% of women booking with the Conquest had their initial assessment after 12 completed weeks of pregnancy. For Eastbourne DGH the proportion was 21%. The national (Vital Signs) target for 2008/09 is that fewer than 25% of women should be assessed after 12 weeks.</li> </ul>
<p><b>Supporting choice in antenatal and postnatal care</b></p>	<ul style="list-style-type: none"> <li>• Ensure that all women and their partners are offered a wider choice of type and place of maternity care and birth.</li> <li>• Information will be made available for women and their partners about the range of choices available to them for antenatal care and postnatal care.</li> <li>• As well as being offered a choice of local services, a woman should be able to choose maternity services outside her area with a provider that has additional capacity.</li> <li>• For choice to be real, it must be backed up by the ability to deliver care in the manner and setting chosen by the woman.</li> </ul>
<p><b>Supporting choice for place of birth (home, midwife led unit or obstetric unit) and between team and midwifery led care</b></p>	<p>Depending on their circumstances, women and their partners will be able to choose where they wish to give birth. These are:</p> <ul style="list-style-type: none"> <li>• a home birth.</li> <li>• birth in a local facility, including a hospital, under the care of a midwife.</li> <li>• birth in a hospital supported by the maternity team including midwives, anaesthetists, consultant obstetricians and paediatricians. For some women this will be the safest option.</li> <li>• We will ensure that women who want a home birth are supported in this choice.</li> <li>• In the short term, we will ensure that all women for whom birth in a local facility under the care of a midwife is appropriate are offered the choice of the Crowborough Birthing Centre. We will also give full consideration to the feasibility of offering midwife led units on one or both acute hospital sites.</li> </ul>

Choice/Service priority	Outcome
<p><b>Ensuring that women are not left alone during labour or birth</b></p>	<ul style="list-style-type: none"> <li>• Evidence suggests that fewer interventions and less pain relief are needed in amongst women who feel well supported in labour. Therefore, we will ensure that women are individually supported and not left alone throughout labour and birth by 2010,</li> <li>• Best practice for achieving this is still being defined nationally. The right number of midwives, appropriately deployed, will be key.</li> </ul>
<p><b>Making sure that we have the right number of staff with the right skills</b></p>	<ul style="list-style-type: none"> <li>• Ensure that there are sufficient numbers of suitably trained and experienced midwives and support staff to work flexibly across community and hospital settings to provide antenatal and post natal care in community as well as hospital settings.</li> <li>• Ensure that the recommended number of hours of consultant presence is achieved on labour wards. ESHT will be asked to develop plans to achieve 40 hours.</li> <li>• The PCTs have made clear that unplanned divers resulting from closures of the units is unacceptable. Despite this the number and duration of closures has increased (2007/8 compared with 2006/7. Work is underway with ESHT to reduce closures).</li> <li>• All women and their babies will receive treatment from health care professionals competent in resuscitation for both mother and infant, and in newborn examination.</li> </ul>
<p><b>Normal birth should be facilitated wherever possible</b></p>	<ul style="list-style-type: none"> <li>• We will support and encourage women to have as normal a pregnancy and birth as possible, with medical interventions recommended to them only if they are of benefit to the woman or her baby. This has been shown to reduce morbidity and improve women's experience.</li> <li>• Caesarean sections will only be used in appropriate circumstances. Where possible breech babies will be turned using External Cephalic Version (ECV) (currently used in significantly fewer cases than expected). Eligible women who have had a previous caesarean will be offered vaginal birth (VBAC) (currently used in fewer cases than expected).</li> <li>• The promotion of normality will require cultural issues to be addressed alongside technical skills development. Midwives and Obstetricians also need to develop their own confidence in supporting normality, and in some cases this will require further training support. Ensuring appropriate staffing levels with appropriately skilled staff is also essential.</li> </ul>
<p><b>Promoting and supporting breastfeeding</b></p>	<ul style="list-style-type: none"> <li>• Services will promote breastfeeding, whilst supporting all women whatever their chosen method of feeding.</li> <li>• A local breastfeeding strategy has been developed to support the implementation of a range of local initiatives towards targets, the action plan to the strategy is</li> </ul>

Choice/Service priority	Outcome
	<p>attached at Appendix D</p> <ul style="list-style-type: none"> <li>Local data on breastfeeding shows that we are not consistently reaching our local target, set by the PCTs, of a minimum increase of 2% year on year in initiation rates with an aim of achieving initiation rates consistently over 80%. Local data has not been available on rates of sustained breastfeeding but is anecdotally thought to be much lower.</li> <li>All women and their partners will be supported with breastfeeding by health care professionals competent in providing breastfeeding support, not only to initiate breastfeeding but will continue to receive support for at least the first six to eight weeks by 2010.</li> <li>An infant feeding specialist has been recruited to coordinate efforts in this area. Data systems will be established and ESHT will be supported to achieve 'Baby Friendly<sup>21</sup>' or other formal accreditation.</li> </ul>
<p><b>Ensuring that all staff are trained and competent in core maternity skills</b></p>	<ul style="list-style-type: none"> <li>All staff that care for labouring women will be expected to maintain their competency in core maternity skills (management of labour, foetal heart rate auscultation and CTG interpretation, skills drill and appropriate resuscitation training) through regular training, and will be supported in this.</li> <li>A database of attendance at mandatory training will be maintained.</li> </ul>
<p><b>Offering high quality (NICE recommended) antenatal screening</b></p>	<ul style="list-style-type: none"> <li>All women will have a personal care plan reflecting their needs and choices.</li> <li>Universal antenatal care will follow the model recommended by NICE.</li> </ul>
<p><b>Identifying problems with maternal mental health and providing appropriate specialist care</b></p>	<p>All women will be assessed for risk of mental health problems emerging, in line with NICE guidance, and specialist care will be provided for women with severe mental illness. We will ensure that all midwives and Health Visitors can recognise maternal mental health issues and make referrals appropriately.</p> <p>Previous poor childbirth experience and fear of childbirth itself can significantly impact upon wellbeing and often lead to distress and requests for elective caesarean birth. This is currently addressed by senior midwives who offer a "listening/debriefing" service from which individual plans of care are drawn. This service will continue to be monitored.</p> <p>The development of a local perinatal mental health service was considered to be a high priority by the MSDP and an outline proposal for developing this</p>

<sup>21</sup> UNICEF baby friendly initiative <http://www.babyfriendly.org.uk>

Choice/Service priority	Outcome
	<p>service has been submitted to the PCT, as part of one of the outcomes from the midwifery and primary care sub group.</p> <p>Women with severe mental illness require access to services provided by specialist mental health services. This includes rapid access to mother and baby inpatient services. We will work with ESHT and other PCTs to resolve the lack of NHS provision of specialist perinatal mental health services within NHS South East Coast. Following the recommendations of Towards Better Births this will require:</p> <ul style="list-style-type: none"> <li>○ Access to a specialist perinatal mental health service with acceptable waiting times for referral. Midwives should be authorised to make referrals.</li> <li>○ A review of their provision of specialist midwives for mental health needs.</li> <li>○ Access to a psychiatric mother and baby unit providing care for mothers with serious mental health needs and their babies.</li> </ul>

### Continuity of midwifery care

3.8 Elements of continuity of midwifery care will include:

- having the time to talk, engage and build a relationship with women and their partners to understand and help meet their needs throughout pregnancy and afterwards.
- ensuring that women and their families are aware of the arrangements for on-going midwifery support and coordination, should the known midwife be unavailable.
- ensuring continuity of care and handover where a woman chooses to give birth outside her area. The midwives in each area are responsible for this.
- providing individual support to women throughout their labour and birth.

### A networked model of care

3.9 The PCT's are committed to further exploring the development of clinical networks and would now like to expand and enhance their roles in continuing to develop World Class Services for the population across East Sussex and to inform the commissioning process. Networks provide the opportunity to break away from the traditional boundaries of primary, secondary and tertiary health care and provide scope for developing services that are more closely linked to the patient's pathway and experience of care.

3.10 The MSDP are working with the Maternity Services CF in taking forward the development of a network model for East Sussex. These developments form a key part of the Maternity Strategy Action Plan. A number of clinical sub groups are working across ESHT to consider the scope of a network model

and how it could support the implementation of targets set out within this strategy. The sub groups are led by key representatives from the Maternity Services CF and report back to the MSDP on progress.

3.11 Some of the more detailed discussion points emerging from the work undertaken by the Clinicians Forum and to be incorporated into the **next steps** included:

- Ensure that what we are putting in place is better than what we are providing now.
- Establish a clear baseline position on current services and standards. This would also incorporate mapping specialist areas and skills.
- Ensure the commitment to continuous improvement through a flexible and organic process (one that can be embedded in the provider/commissioner framework).
- Work with the providers through the IRP programme to support capacity in managing the change process and strengthening internal networks.
- Put in place clear criteria to evaluate the sustainability of the model with reference to capacity planning, skills mix and changing professional roles.
- Build an integral network linked to the operating framework for maternity services in East Sussex across the two hospital sites (Eastbourne and Hastings) and strengthen this through ensuring linkage between a local clinical sub group and the wider Sussex Maternity Network. This still allows for synergy across existing networks with Brighton and Hove and extend the scope for incorporating more formal arrangements in relation to training and neonatal services.
- Ensure the scope for developing extended networks that strengthen care pathways.
- Ensure that primary care forms part of the extended or more formalised network.
- The opportunities linked to the network model were recognised as including:
  - Sharing learning
  - Agreeing protocols and standards
  - Developing agreed care pathways and strengthening practice at a strategic and operational level.
  - Sharing workforce options and developing the potential for shared appointments between Trusts
  - Shared Education and Training
  - Wider access to highly specialised skills
  - Enhancing neonatal services

## 4 Commissioning the maternity services commitment

- 4.1 Commissioning is the key to effective delivery of the maternity strategy. The PCTs have benchmarked their capacity and capability to commission maternity services using the Maternity Matters Commissioning Self-Assessment Tool. This confirmed that although the PCTs have a good understanding of the needs of the population in relation to maternity services and is actively involved in improving services through this strategy, it will be necessary to appoint a named lead commissioner for maternity services in order to maintain the required focus and drive into the future. Steps being taken to develop as world class commissioners will also have a positive impact on the PCTs' ability to act as an effective commissioner of maternity services.

### Local commissioning framework

- 4.2 The commissioning of maternity services will be used together with the national choice guarantees as a way to drive the essential improvements in the quality, safety and accessibility of services. In line with the commissioning framework for health and well-being our local commissioning framework incorporates the following key mechanisms:
- Strategic Needs Assessments.
  - Publication of Primary Care Trust (PCT) prospectuses.
  - Joint working proposals for developing and delivering proposals for improving maternity services.
  - Practice-based Commissioning (PBC) and impact on the re-design of services.

### Strategic Needs Assessment

- 4.3 This section sets out the PCTs' approach to Strategic Needs Assessment incorporating:

***An assessment of current commissioning processes to support the delivery of effective, high quality maternity services.***

- 4.4 The PCT's are committed to increasing the scope of their service agreements with providing trusts, particularly to include quality and ensuring that the funds provided for maternity services are closely monitored and spent on maternity care.
- 4.5 Trusts are required by Towards Better Births to review their costing information to ensure that their reference costs accurately reflect the costs of providing their maternity service.

### **Review of contracts**

- 4.6 Contracts will be developed for maternity services based on the service models described within this strategy, and setting out challenging but achievable standards as an integral part of the agreement, reflecting local and national standards and local needs.
- 4.7 The existing block contract that covers all community midwife services (except home delivery) will be reviewed to develop a local activity, quality and outcomes based contract with a local tariff. External expertise will be needed to support and facilitate this process which is critical to the success of the strategy. Ensuring that the contracts between the PCTs and our main provider are put on a sound footing is essential before any consideration of commissioning 'enhancements'. This review should incorporate a thorough review of the cost base, coding and payments associated with the whole maternity contract because the community elements cannot be neatly separated from hospital based services by providers. The indicative tariff for community maternity services developed by the DH will be helpful in taking this work forward. Work on this started in 2009 through the formation of a Maternity Finance and Commissioning sub group. The remit of this group is to manage the ongoing process for agreeing commissioning priorities and targets year on year including the review of performance monitoring data (incorporating cost and activity levels). To date both predictive modeling and benchmarking data have been utilised to support a review of maternity costs and scope service development and re-design initiatives in this year and beyond. The clinical sub groups formed as part of the work undertaken by the Clinicians Forum in 2009 each produced a range of core and developmental service priorities. These will be considered by the commissioning group alongside those "core maternity services" already described in the strategy each year. Prioritisation work has already been completed in relation to those services that would be deemed a high priority in years 1,2 and 3 of the strategy.

### **Contract monitoring**

- 4.8 Contract monitoring will be supported by the collection of a range of indicators focused on quality and outcomes. Effective monitoring of performance is expected to show up areas where further targeted action is needed, leading to continued quality improvement.

### **Outcomes from the East Sussex Maternity Service Health Impact Assessment**

- 4.9 The Health Impact Assessment conducted by Public Health on behalf of the Boards during consultation recommended that the most deprived women need to be enabled to have priority access to the full range of services on the maternity clinical pathway. Preconception, antenatal and postnatal care need to be offered using community outreach 1:1 support. Effective antenatal care targeting disadvantaged mothers was considered the highest priority. A summary of the key findings are as follows:
- **Higher risk pregnancies and "joined up services"**: these need to be supported by good antenatal care that is midwife-led with improved community-based support. Aspects of this included early assessment mechanisms and clear links and signposting to other services to support women with problems

such as mental health or substance misuse issues. The need for multi-agency and multidisciplinary approaches and assertive outreach model were discussed and endorsed. Ideas to improve access included walk-in services, reaching women “where they are” (home, school) and “one stop shop” approaches to “capture” women with high risk pregnancies, social care issues or lifestyles were highlighted.

- **Support for groups known to have poorer outcomes:** enhancing access to community midwifery and community obstetrics services in social disadvantaged areas should increase early uptake of antenatal care and lead to better management of risks with better outcomes for mother and infant. One member of the group spoke of “pram distance” being crucial for more vulnerable groups.
- **Specialist roles and type and skill mix of staff providing antenatal care** need to be considered and the case for Health Trainers and Peer Support type roles in addition to midwives. The expansion of midwife numbers and supervision and up-skilling of midwives was also highlighted. In addition, the role of community-based Consultant role to support midwives and primary care in supporting their roles in relate to “at risk” pregnancies.
- **Focus of resources:** Care should be provided and focused in the most disadvantaged areas and areas of greatest need.
- **Deprivation and Poor Outcome** - The link between deprivation and greatest risk for poor outcomes for mother and baby was accepted.
- **Priority access for services** - The most deprived women need to be enabled to have priority access to the full range of services on the maternity clinical pathway. Preconception and antenatal services need to be offered using community 1:1 support.
- **Specialist obstetrics and Special Care Baby Unit (SCBU) services** - The most deprived women are more likely to have greatest needs for high quality specialist obstetric and SCBU services. Their access to these services needs to be facilitated to enable them to receive care closest to where they live to maintain family support networks.
- **Postnatal care** – The most deprived women and their babies are likely to have greatest needs for community outreach 1:1 support in the postnatal period.

### Capacity Planning

- 4.10 The PCT's took account of the population projections in their decision making. They noted that projections are just that, and even the best projections are associated with a level of uncertainty. The Boards therefore decided that it would be prudent in planning future services to assume the continuation of

current levels of capacity. The Boards also committed themselves to moving towards the levels of midwife staffing recommended in 'Safer Childbirth<sup>22</sup>' and as calculated using the Birthrate Plus tool. Birthrate Plus calculations are based on the number of women and babies to whom care is being provided (including antenatal and postnatal care, and not just births). This therefore provides an additional assurance that staffing will flex with demand, whatever future activity is seen.

#### **Role of the Maternity Services Liaison Committee.**

- 4.11 In East Sussex the MSLC has previously been hosted by ESHT. In line with national guidance the PCTs will take over the hosting of the MSLC. As part of this process a review of arrangements will be undertaken to ensure that the committee is set up in the best way possible to support members in effectively engaging with service providers and commissioners. This will include ensuring that the recommendations of Towards Better Births are met. At least one third of the core membership of the MSLC should be made up of user representatives and the profile of the MSLC should be raised with an annual programme of work and annual recommendations to the trust and PCT board.
- 4.12 Commissioners have not previously been active MSLC members in East Sussex. The appointment of a lead commissioner for maternity will support the active participation needed.

#### **Review of the current midwifery workforce.**

- 4.13 The PCT's are committed to ensuring that there are sufficient numbers of suitably trained and experienced midwives and support staff working flexibly across community and hospital settings providing antenatal and post natal care in community as well as hospital settings. All women and their babies will receive treatment from health care professionals competent in resuscitation for both mother and infant, and in newborn examination.
- 4.14 All staff will be expected to maintain their competency in core maternity skills (management of labour, foetal heart rate auscultation and CTG interpretation, skills drill and appropriate resuscitation training) through regular training, and will be supported in this.

#### **Workforce for the Women's Health Directorate**

<b>Role</b>	<b>Funded WTE</b>	<b>Headcount</b>
Midwife	134.71	125.70
Healthcare Assistant	27.90	29.41

*(Source: ESHT ESR as of 1/11/09)*

<sup>22</sup> RCOG, Safer childbirth minimum standards for the organisation and delivery of care in labour, October 2007

### **Birthrate plus calculations.**

- 4.15 Birthrate Plus is a nationally accepted tool for calculating the required number of midwives based on demand (births and case mix). A Birthrate Plus calculation was undertaken by East Sussex Hospitals in June 2008

which at that time showed that an additional 10.26 whole time equivalent midwives were still needed. Over the last two years (2008 – 2009) the PCT have funded an additional 10 midwives. Birthrate Plus was updated again in 2009 and the revised shortfall is now 13.03 that will reduce down to 11.94 with the outsourcing of parent education. It is recognised that meeting Birthrate Plus calculations are challenging for many areas and locally a range of measures to ensure the most effective, innovative and productive use of resource are being considered.

### **Commitment to community midwifery.**

- 4.16 In line with the PCTs' explicit commitment to enhance community services, ESHT envisages that this additional establishment is targeted at community midwifery services in order to facilitate the required relocation into local Children's Centres in order to offer women the full range of choice.
- 4.17 A fully established community workforce will also facilitate more innovative community based models of care (such as hospital/birthing centre birth with community midwife as well as potentially increased homebirth capacity). This in turn will relieve pressure on hospital-based teams. It is envisaged that a more integrated community/hospital model of care will be established.

### **Preparation for geographic working (restructuring teams)**

- 4.18 Midwife numbers, ways of working and skill mix need to be appropriate to meet the PCTs' strategic aims, including specific commitments to continuity of care through the antenatal and postnatal periods, and 1 to 1 care in labour.
- 4.19 Investment in the midwifery workforce is required, but this in itself is not enough to achieve the aims of this maternity strategy without significant restructuring of midwifery community services into effective, well structured teams with appropriate team leaders. It is therefore also proposed that in addition to investment in the overall community midwifery establishment, another vital step for ESHT is a restructure of community and Crowborough Birthing Centre teams in preparation for geographic working and caseloads. This is pivotal to working towards the above and the wider Maternity Matters agenda and is also in line with the PCTs' specific commitment to strengthen antenatal and postnatal care.
- 4.20 Currently Community Midwives operate from a variety of "bases" e.g. Eastbourne DGH, Conquest Hospital, Crowborough Birthing Centre, Uckfield Hospital, Bexhill Health Centre, Heathfield Health Centre. They are linked to GP surgeries and their caseloads are therefore defined by GP lists. This results in inequity in terms of the numbers of women allocated to individual midwives and ultimately inequity in terms of midwifery time available for individual women.
- 4.21 In order to distribute caseloads more equitably, to offer women the choice of direct access to midwives it is proposed that ESHT will move towards Community Midwives being based in geographically determined teams.

- 4.22 A detailed operational plan has been agreed and includes all aspects of organisational change that may need to be addressed to implement changes. The group has scoped this and envisage this will include:
- CPD for all nursing maternity services employees.
  - Training to develop clinical skill mixes.
  - A change of geographical base.
  - Increased mobility.
  - A change of working practice to work collaboratively in line with national drivers and requirements.
  - Negotiation with GPs and other stakeholders regarding proposed clinic venues.
  - Review/investment in IT in community settings

### **Local quality standards and incentives**

- 4.23 Three sets of clinical indicators are in development in East Sussex (see below). Each indicator in the ESHT Maternity Dashboard and the Maternity Strategy Indicators use a Red Amber Green rating approach where green is set as the local target and red as an action level. These have been developed locally, based wherever possible on national guidance, local expert opinion and previous local performance, and are still under development.
- 4.24 The three sets have been developed separately, and now need to be harmonized. To take account of a parallel regional initiative. ESHT and the PCTs need to work together to ensure that data quality and presentation issues are resolved, overlaps removed and the usefulness of the data presented tested with users. In addition a number of indicators have been included for which further work on definitions and on setting up systems of data recording will be needed. An example is the provision of 1:1 care in labour for which there are no nationally agreed definitions (for example does continuity of care mean no breaks at all, and does the carer always need to be a qualified midwife?) and for which there are no systems in place to record the data.
- 4.25 Fit for Future indicators agreed with South East Coast Strategic Health Authority. These relate to collecting baseline data so that the impact of service reconfiguration can be monitored over time. The indicators include those relating to service delivery and capacity, adverse events, deprivation, and outcomes.
- 4.26 Most of these indicators will be reported monthly but in some cases this is not appropriate, either because the rate of change is slow or intermittent or because monthly data would not be meaningful, so this data will be included in an annual report. Examples would be:
- CNST status which is reassessed only every three years.

- Development and review of local protocols which are normally revised on a rolling programme over several years.
  - Mortality rates where longer run data is needed to give meaningful comparisons.
- 4.27 **ESHT Maternity Dashboard:** a set of indicators based on an approach developed by the Royal College of Obstetrics and Gynaecology. East Sussex Hospitals Trust have started to use the dashboard and are providing the PCTs with regular information. The dashboard will support maternity services staff to monitor performance on a monthly basis. Pre-agreed upper and lower limits will alert staff when action needs to be taken. The indicators include areas relating to activity, workforce, and clinical indicators.
- 4.28 **Maternity Strategy indicators:** an additional indicator set encompassing other quality standards for maternity care including the national guidance set out in Maternity Matters, adopting the dashboard format with clear action levels. These include fertility rates and numbers of women with mental health and substance misuse problems. These will be reported monthly.
- 4.29 In addition, the PCTs will also receive regular information on all serious untoward incidents relating to maternity and the action plans to reduce the likelihood of these reoccurring.

#### **Ensuring that robust cost and activity data are available for all maternity services**

- 4.30 Trusts are required by Towards Better Births to review their costing information to ensure that their reference costs accurately reflect the costs of providing their maternity service.
- 4.31 In order to meet these ends and to move away from a dependency by ESHT on subsidy outside tariff for maternity services the PCTs will work with ESHT to ensure that their costs are reduced to an acceptable level, offering value for money to the local community.
- 4.32 The King's Fund in their report 'Safe Births' highlight the importance of timely and appropriate information in assuring the quality and safety of maternity services. This is true for services that are working in a stable, unchanging environment, but applies to an even greater extent in East Sussex where significant change to maternity services is planned, and where there is therefore a need to closely monitor the impact of those changes to service provision to ensure that they have the desired effects and that quality and safety are enhanced as a result.
- 4.33 The purpose of data collection is both to provide maternity teams with manageable amounts of information about their own performance, combined with information about national performance that they can use for benchmarking purposes, and to inform future planning and commissioning.

#### **Implementation planning**

- 4.34 The planning for maternity services will be undertaken in partnership with other organisations including local authorities. Local commissioners, providers, staff and service users are best placed to determine the most

effective method of ensuring improved access to care for the most vulnerable in their communities.

### **High quality and safe services**

- 4.35 The PCT's recognise the level of responsibility that providers have for clinical care at the point of contact to ensure the delivery of high quality, safe and effective maternity services. We are committed to achieving the best possible standards of care through:

#### **Women focused and family centered care**

- 4.36 We will ensure that women are individually supported and not left alone throughout labour and birth. Evidence suggests that fewer interventions and less pain relief are needed amongst women who feel well supported in labour. Best practice for achieving this is still being defined nationally. The right number of midwives, appropriately deployed, will be key.
- 4.37 We will ensure that there are sufficient numbers of suitably trained and experienced midwives and support staff to work flexibly across community and hospital settings to provide antenatal and post natal care in community as well as hospital setting.

#### **Provision of more senior cover on labour wards**

- 4.38 We will ensure that the recommended number of hours of consultant presence is achieved on labour wards. ESHT will be asked to develop plans to achieve 40 hours.
- 4.39 All staff that care for labouring women will be expected to maintain their competency in core maternity skills (management of labour, foetal heart rate auscultation and CTG interpretation, skills drill and appropriate resuscitation training) through regular training, and will be supported in this. A database of attendance at mandatory training is maintained and shows that uptake of training has not always been good especially amongst doctors. Advanced neonatal resuscitation training has not been offered to all midwives. Steps will be taken to ensure all staff complete mandatory training.

### **Care pathways**

- 4.40 In developing networks and pathways for clinical care, the PCT's recognise the importance of clinical leadership and multidisciplinary working. All clinicians providing care need to recognise each other's responsibilities within the team to improve safety. Within the network, at all stages of pregnancy and postnatally, women require access to the appropriate professional to give information, advice, care and support, however simple or complex the need.
- 4.41 The PCT's recognise the benefits of utilizing the patient pathway approach used in the NSF as a tool to ensure a comprehensive multi-agency approach towards service delivery.

### **Reporting**

- 4.42 Safety and quality information will be reported regularly to frontline staff through the maternity dashboard.

## A skilled workforce

- 4.43 The PCT's are committed to developing a competent and robust workforce to ensure the delivery of the pledges set out in this maternity strategy. The MSDP acts as the accountable body for reporting to the Boards on progress against the strategy and a workforce sub group has been established. The work programme for the sub group includes addressing national and local priorities, incorporating any workforce reconfiguration that results from the implementation of the IRP recommendations.

### ***The main objectives of the work force sub group are to:***

#### **Establish Safe staffing levels**

- Develop workforce plans to achieve national and local targets for 40 hours consultant presence on labour ward (including making recommendations on the workforce requirements to meet this objective, both numbers and deployment), and monitor their implementation.
- Develop plans to ensure that the numbers of neonatal staff are in place to meet local needs.
- Ensure that only suitably experienced and qualified midwives work provide midwifery-led births in community settings (home births and birthing centres) and that appropriate induction and training is provided for these staff.

#### **Implement the European Working Time Directive**

- Develop workforce plans to ensure EWTD compliance.

#### **Increase workforce capacity**

- To advise on approaches to enhance the recruitment of hard to recruit groups (in particular middle grade O&G doctors).
- Develop workforce plans to achieve birthrate-plus midwifery staffing and monitor its implementation.
- Develop workforce plans to ensure there are sufficient suitably trained staff to deliver community based care, achieve continuity of care through the antenatal and postnatal periods and 1 to 1 care in labour (including making recommendations on the workforce requirements to meet this objective) and monitor its implementation.
- To provide expert advice on workforce planning to help achieve the objectives of the other work streams.
- To support the delivery of outreach services through supporting the workforce to provide services in new ways.

#### **Ensure ongoing staff development**

- All midwives providing services in East Sussex have undergone training in advanced obstetric life support.

- All midwives providing services in East Sussex have undergone training in the recognition of maternal mental health issues and appropriate referral.
- That training and mentoring is provided to midwives to develop their skills and confidence in natural and normal birth.

- **The scope of the workforce sub group includes:**
- Assessing the current baseline of the maternity workforce by using appropriate workforce planning tools and identifying future workforce needs to produce a sustainable work force to achieve the objectives of the Maternity Strategy Working Group.
- Developing roles that support identified services agreed by other workstreams e.g. making the Outreach midwives a permanent service to address any gaps in workforce provision. This will include accommodating geographical variations to support new or different ways of working.
- Working collaboratively to share skill mix across partners e.g. community and acute.
- Designing effective ways to address local staffing issues.
- Ensuring an appropriately skilled maternity workforce with regular continuing professional development is in place.
- Promoting strong leadership and an open, supportive work culture.

### **Geographical variations**

- 4.44 At present many of our midwives are skilled and experienced in the context of hospital based practice alongside Obstetricians. It is recognised that working in community settings including birthing centres requires a different skill set. The PCTs have given a commitment that only suitably experienced and qualified midwives will provide midwifery led births in community settings (home births and birthing centres) and that appropriate induction and training is provided for these staff. To ensure that there are sufficient appropriately skilled and experienced midwives, and with the aim of increasing the flexibility of the workforce, University of Brighton have been commissioned to pilot a skills audit exercise with the Crowborough Birthing Unit and Community Teams. A postal code mapping exercise to develop identified skills in the most appropriate parts of the service across the county is also being completed. Based on this a training programme will be developed. A significant number of employees in all three major staff groups work part time hours. This will be critical when determining the distribution of skills and services across the county.

## Monitoring framework

### ***Monitoring the Maternity Strategy.***

4.45 East Sussex have developed a performance management framework for maternity services to ensure that the targets and pledges set out within the maternity strategy are monitored. A set of clinical indicators have been set and agreed with the Strategic Health Authority (SHA) to monitor the impact of any service reconfiguration and assure patient safety and improved clinical quality. A maternity services dashboard provides a cohesive framework within which key performance indicators and other national/local standards are monitored on a monthly basis.

### **Corporate performance management**

4.46 Performance management within the NHS is evolving. Work is still underway on creating the regulatory framework within which the new, reformed NHS will operate. *Health Reform in England: update and commissioning framework* signalled a shift from the existing DH target driven system.

4.47 Post 2008, a metrics based system will be in place within a context of quality and safety requirements. Foundation Trusts will continue to be regulated by *Monitor*, an independent regulatory body, which authorises, monitors and regulates NHS Foundation Trusts and can intervene if they are deemed to be failing in their healthcare standards or breaching their terms of authorisation.

4.48 ***A Quality Improvement and Clinical Outcomes Group*** was setup in June 2008 to take forward two key areas of work.

4.49 Following the PCT's World Class Commissioning (WCC) event, it was decided to develop a work stream to identify factors for determining and ways of monitoring robust clinical outcomes.

4.50 The Clinical Governance Committee recognised the need to set up a sub group to identify, establish, develop and prioritise Key Performance Indicators and clinical outcomes, measure change and evaluate the benefits.

4.51 The group will lead on the quality work programme and is chaired by the Director of Public Health and Medical Director. It has representation from all directorates across both PCTs along with PEC members and GP clinical governance leads.

4.52 The vision for the group is to:

- Meet and surpass the expectations of our patients for high quality safe services.
- Understand and respond to needs,
- Identify factors for determining robust clinical and quality outcomes
- Ensure monitoring and continuous improvement takes place.

## Current performance indicators relating to quality

**4.53** The Quality Improvement and Clinical Outcomes Group will have an overview on the range of performance indicators operating across the PCT. The maternity strategy and dashboard forms a part of the corporate quality framework. Other indicators that inter-relate with the Maternity Dashboard include:

### World Class Commissioning indicators

4.54 **Health Status Dashboard** containing health improvement and health protection indicators. This dashboard is reported regularly to both PECs and PCT Boards. The latest dashboard is included within the PCT performance report.

4.55 **Sussex Partnership NHS Foundation Trust:** A Service Level Agreement with the Mental Health Trust that covers East Sussex has been developed to include items such as SUI and patient safety reporting, quality of care, patient discharge, clinical governance and audit and many more areas.

4.56 **Healthcare Commission Annual Health Check.** The Healthcare Commission Annual Health Check measures the performance of the PCTs against national targets that include indicators on the quality of care received by patients and the health outcomes experienced by the population. The PCT performance report details the indicators that will be used to assess performance in 2008/9 and also provides an update on the performance to date in 2008/9 and details where plans are in place to address performance issues.

4.57 **Measuring Quality within Community Services** Following discussions at the PCT Professional Leads Group and with the Modern Matrons concerning the development of clinical metrics three areas have been developed around Essence of Care, PCT clinical performance metrics and Patient Experience Tracker

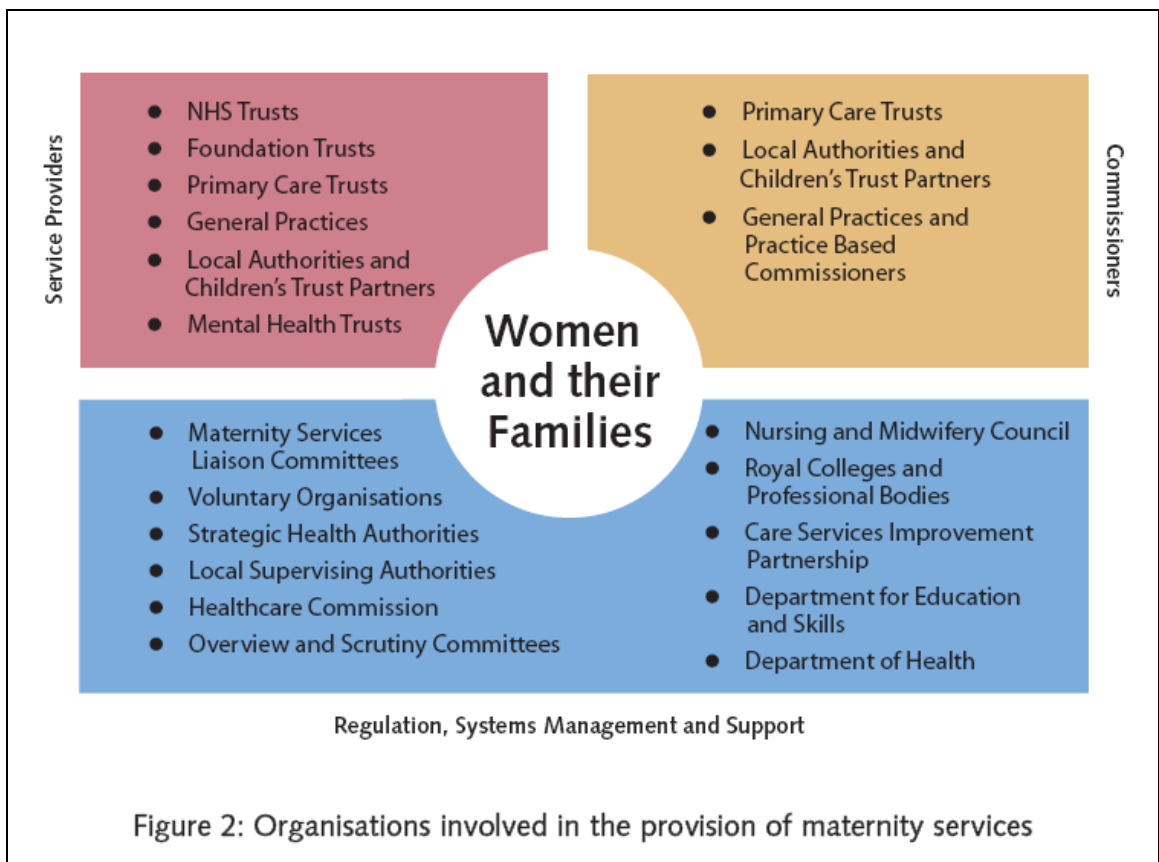
4.58 **Primary Care** The PCT Primary Care team are developing a **Primary Care Balanced Scorecard** to cover a range of indicators relating to access to services and quality.

4.59 **There are a number of National developments** in relation to performance management and maternity services that East Sussex Downs and Weald PCT will be keen to incorporate into its local framework including:

- The maternity dataset currently being developed to support the implementation of the NSF. It is being designed for secondary use purposes e.g. planning and commissioning of services rather than direct care of the patient and will be derived from information already, or anticipated to be, captured in the electronic care record (a primary source of data).
- Healthcare Commission national surveys and annual health checks and work with RCOG to ensure that evidence based clinical guidance and standards are being developed.

# 5 Roles and responsibilities

5.1 Successful provision and delivery of the best possible maternity services, including choice, will require full engagement of all service providers, commissioners and organisations that facilitate regulation, systems management and support. The diagram features the women and their families at the centre of the provision of woman-focused, family-centred maternity services and below that are likely roles and responsibilities for each type of organisation.



## 5.2 Service providers and commissioners

### **NHS Foundation Trusts, NHS Trusts, Ambulance Trusts and other maternity service providers:**

- Deliver high quality, safe and responsive maternity care with appropriate levels of trained staff in compliance with national guidance e.g. NICE. Clinical care should be regularly audited and poor outcomes must be subject to detailed review. The findings of audits and reviews must be acted upon.
- Be responsible for the environment, facilities and timeliness of services, including transfers, that are essential for women-focused, family-centred care.
- Support PCTs in planning and monitoring maternity care.
- Gather and report routine data including specific maternity activity as required through the monitoring framework.
- Be responsible for developing their workforce for maternity services, ensuring that they have sufficient appropriately trained staff who undertake continuous professional development.
- Ensure board regularly reviews the performance and function of maternity services.

### **Primary Care Trusts**

- Develop the local vision for maternity services in consultation with key stakeholders and local authorities and publish it in the annual PCT prospectus.
- Assess current services, identify gaps and the barriers to service development then set out the local strategy for meeting the maternity commitment by the end of 2009.
- Assess the current baseline of their maternity workforce, use appropriate workforce planning tools, such as the CSIP Maternity Tool and Birthrate Plus, to identify future workforce needs and take action to address any gaps in workforce provision including the development of new skills and roles.
- Commission high quality, equitable, integrated maternity services as part of local networks according to local need. Critically this will include developing and agreeing clinical protocols and maternity service pathways in line with the NSF and the national choice guarantees.
- Engage with the local population to ensure that maternity services are developed in line with local needs and priorities.
- Ensure all maternity service professionals receive regular continuing professional development and understand how the local network functions.
- Monitor the performance, quality and safety of maternity service providers.
- Ensure the provision of high quality information to enable informed choice.

## **General Practices**

- Work with PCTs to commission a comprehensive and equitable range of high quality, responsive and efficient maternity services that reflect local need.
- Ensure that high quality, responsive maternity services are provided, including general medical services for pregnant and postnatal women.
- Work with PCTs and providers to agree clinical protocols and pathways within local networks and assist women and their partners in considering their options for antenatal, birth and postnatal care.
- Refer all pregnant women to maternity services as soon as possible.
- Provide the relevant medical and social history to the midwife responsible for the care of the pregnant woman regardless of which referral route has been chosen.

## **Local Authorities and Children's Trust Partners**

- Support the development of local networks.
- Work in partnership with PCTs to develop Children's Centres which include maternity services.
- Meet duties under Childcare Act 2006 and work with NHS partners to improve the outcomes of all children up to 5 and reduce inequalities between them, by ensuring early childhood services are integrated to enable easy access. This will involve informing Local Area Agreements and Children's and Young Peoples Plans.

## **Mental Health Trusts**

- Work with PCTs to agree clinical protocols and pathways for seamless care for pregnant or recently delivered women with mental health problems.
- Ensure the provision of the specialist perinatal psychiatric services for women with serious mental health disorders and provide services to inpatient mother and baby units for those women who require admission.

## **2.3 Regulation, systems management and support**

### **Maternity Services Liaison Committees**

- Advise PCTs and maternity service providers on all aspects of maternity services.
- Monitor progress of service development against an annual plan.

### **Voluntary Organisations**

- Provide patient and parent representatives.
- Provide a range of services including support and information.
- Contribute to local consultations.

## **Strategic Health Authorities**

- Provide strategic leadership to assist PCTs in the development of the local vision for local maternity services, the development of networks and of user involvement.
- Oversee and contribute to the development of the workforce strategy, workforce modernisation and workforce development.
- Ensure that opportunities exist for three year and 18 month pre-registration programmes and flexible return to practice midwifery programmes.
- Hold PCTs to account for commissioning comprehensive maternity services.
- Ensure that Local Supervisory Authority standards and activities promote safe, high quality care for women and their babies and monitor standards of midwifery practice.
- Ensure that the local community has representation on a local MLSC or equivalent and other user involvements groups e.g. LINKs.

## **Local Supervising Authorities (Midwifery)**

- Monitor maternity service interface with clinical governance structures and mechanisms across the SHA, to identify trends and provide a framework for continuous improvement in both individual services and across networks.
- Monitor service developments and reconfigurations to ensure that safety and quality is assured.
- Monitor staffing levels, workforce planning and professional development to ensure that women are able to access services which are fit for purpose.
- Contribute to educational fora to ensure that curriculum development reflects the needs of a modern maternity service.

## **Healthcare Commission**

- Undertake and report on the Maternity Services Review and women's experience survey in 2007.
- Maintain oversight of organisations' approach to care through the Annual Health check, local presence and investigations activity.

## **Overview and Scrutiny Committees**

- Provide scrutiny and challenge around the role and integration of maternity services with local authority-provided services

## **Royal Colleges and Professional Bodies**

- Define measurable standards for the skills, competencies and regular continuing professional development needed for the provision of maternity services.
- Support the development of the curriculum requirements for postgraduate education and training in maternity services.
- Facilitate multidisciplinary learning so that all clinicians train in a way that recognises each other's responsibilities within the team to improve care and safety.

### **Nursing and Midwifery Council**

- Set the curriculum requirement for pre-and-post registration education and quality assure nursing and midwifery education including regular continuing professional development.
- Set standards and provide guidance for LSAs for the supervision of midwives and provide midwifery guidance and advice.
- Ensure midwives and nurses are on the relevant professional register, are compliant with continuing professional development and have processes in place to address allegations of professional misconduct.

### **Care Services Improvement Partnership**

- Provide regional and local support to enable implementation and support the development of networks.
- Enable use of tools and improvement methodologies to support change in local maternity services and facilitate sharing and spread of good practice.

### **Department for Education and Skills**

- Ensure that the programme for the development of Sure Start Children's Centres takes into account the requirements of maternity services.

### **Department of Health**

- Develop national policy and guidance to support and enable local implementation.

## 6 Conclusion

- 6.1 The future belongs to our children, with their mothers and fathers as custodians. Nothing can therefore be more important than cherishing and providing the best possible care for all our pregnant mothers, expectant fathers and babies, and equipping new parents with the skills and support they may need to enable every child to have an equal, confident and healthy start to family life.
  - 6.2 This Maternity Strategy sets out how the PCT's will improve choice, access and continuity of care in maternity services, putting women and their partners at the centre of local maternity service provision. This strategy highlights how commissioners, providers, maternity professionals and user representatives will be able to shape provision to meet the needs of women and their families.
  - 6.3 We recognise how ambitious some of the targets are but are confident that through the development of a robust network model and commitment from all key partners and stakeholder there is an opportunity to achieve a World Class Maternity Service for women, expectant fathers and their babies in East Sussex.
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