Agenda Item 5

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**19th March 2009**
By:	**Director of Law and Personnel**
Title of report:	**Developing Maternity Services for East Sussex**
Purpose of report:	**To summarise progress in relation to the development of maternity services in East Sussex.**

RECOMMENDATIONS

HOSC is recommended to:

1. **Consider and comment on progress with implementing HOSC and IRP recommendations as summarised in appendices 1-3.**
2. **Support the direction of travel outlined in the Maternity Strategy (appendix 4)**
3. **Support the network approach to maintaining and developing obstetric services in both Eastbourne and Hastings (outlined in appendix 5)**
4. **Consider and comment on the draft engagement plan (appendix 6)**
5. **Request a further monitoring report in July 2009.**

1. Background

1.1 Following the outcome of the East Sussex Primary Care Trusts' (PCTs') consultation on the configuration of maternity and related services, HOSC agreed to undertake ongoing monitoring of progress. This has focussed on four areas:

- The maintenance of safe childbirth services in Eastbourne and Hastings pending the development of a long-term sustainable model.
- Progress on the development of a service model which would ensure the continuing provision of consultant-led childbirth, special baby care and inpatient gynaecology services at both hospitals.
- Progress on the development of a broader maternity strategy for East Sussex which would include enhancements to ante and post-natal care.
- The development and use of a 'maternity dashboard' which would provide a selection of data about maternity care to facilitate monitoring of quality and safety.

1.2 At the HOSC meeting on 27th November 2008, the Committee noted that new governance arrangements were being established to take forward work on maternity strategy, including the development of a model for childbirth services in Eastbourne and Hastings. These arrangements included a Maternity Services Development Panel and a Maternity Services Clinicians Forum. The HOSC Chairman had agreed to join the Development Panel as an independent observer and independent Chairs were being sought for both groups.

1.3 HOSC also heard that three main projects were already underway to develop ante and post natal care and these would be integrated into the maternity strategy. The projects are:

- The Family Nurse Partnership – a pilot programme offering intensive support to first time young mothers in the Hastings and St Leonards area.

- Geographical working for midwives – the restructuring of community midwifery to provide more locally accessible ante and post natal services.
- Perinatal mental health – the implementation of a perinatal mental health network across Sussex and the development of integrated care pathways to improve outcomes for women and their families.

1.4 The PCTs confirmed that a draft maternity strategy had been developed and would be taken forward through the new governance arrangements. An indicative timescale suggested that the maternity strategy and new model for childbirth services would be developed by the end of March 2009. Final decisions would be taken by a joint committee of the PCT Boards.

2. Progress update

2.1 The Maternity Services Development Panel and Clinicians Forum held their first meetings in January 2009 and Chairs have been appointed for each. Richard Hallett, Chair of the East Sussex Maternity Services Liaison Committee, chairs the Development Panel and Professor Robert Shaw of the Royal College of Obstetricians and Gynaecologists chairs the Clinicians Forum. The two groups have been working towards the development of a service model for childbirth and related services and a first iteration of a maternity strategy for East Sussex. **The attached appendices provide HOSC with an overview of progress to date**:

2.2 **Appendix 1** is the updated HOSC monitoring template. This lists HOSC Fit for the Future report recommendations which remain relevant, plus the recommendations of the Independent Reconfiguration Panel (IRP). Against each recommendation is a reminder of the last reported status to HOSC (November 2008) and the latest status (March 2009). This enables HOSC to gain an overview of progress on developing maternity services.

2.3 **Appendix 2** is the latest version of the maternity indicators developed to help monitor the quality of care on an ongoing basis.

2.4 **Appendix 3** is an update on recruitment to the Family Nurse Partnership Programme, requested by HOSC in November 2008.

2.5 **Appendix 4** is the first iteration of a Maternity Strategy for East Sussex. This strategy focuses on maternity services on the basis that this is a prerequisite for sustainable inpatient gynaecology services and special care baby services. These services will as a minimum be maintained, but are expected to be enhanced by the new model of care. The strategy contains a short section on the service model for childbirth services. A more detailed paper describing the 'network model' of care is included as appendix 5 - this model is being used in other areas of England, most notably the East of England. The programme of work is also supported by a detailed project plan which is also available on the PCTs website. The document focuses on a high level vision and direction of travel for maternity care over the next 3 years, with particular emphasis on community services. The document will be considered by the PCT Boards at the end of March and **HOSC is invited to support this first iteration of the strategy in advance of the Boards' decision**.

2.6 **Appendix 5** is a paper outlining the principles of a network model of services. The Clinicians Forum has recommended that this forms the basis of a future model for childbirth services for East Sussex. The intention is for the Clinicians Forum and its sub-groups to further develop this model over the coming months and flesh out how it would work in practice. The focus is on networking between the two East Sussex hospitals and Brighton, which is the local tertiary unit. **HOSC is invited to support this network approach as the basis for developing a sustainable model for childbirth services in Eastbourne and Hastings**.

2.7 **Appendix 6** is the draft engagement plan prepared by the Development Panel. It outlines principles for future engagement and key audiences. It is based on the premise that existing groups and communication methods should be utilised wherever possible. **HOSC is invited to comment on the plan**.

3. Issues to consider

3.1 HOSC may wish to explore the following issues:

- How a network model can address issues such as increased consultant presence on labour wards, unplanned closures, and training and skills maintenance for doctors.
- How choice for women will be considered within the development of a network model.
- How the plans for community services will be progressed.
- Whether the strategy will address issues of health inequality.
- The timescales for implementation of changes to community services and implementation of a fully developed network model for childbirth services?
- Whether the engagement plan includes all the key audiences and main routes for communication and involvement.

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HOSC monitoring template - Developing Maternity Services in East Sussex **Item 5 - Appendix 1**

This table lists the recommendations made by HOSC in relation to the proposals for maternity, inpatient gynaecology and special baby care services ***which remain relevant following the decision that services should be retained at both main hospital sites***. Following this decision, the template also includes the recommendations made by the Independent Reconfiguration Panel (IRP) to enable HOSC to monitor progress on these also.

	Recommendation	Last reported status **November 08**	PCTs' Progress report **March 09**
Recommendations relating to implementation of changes *(N.B. although services will now remain on two sites, there are likely to be changes to the way these services are provided, therefore the recommendations below remain relevant)*			
R4	Before any decision is taken to implement changes to services, the PCT Boards should ensure robust capital and revenue costings are in place and local health economy sources of funding clearly identified. Sources of funding should minimise the impact on other services as far as possible.	Revenue and capital plans as well as local health economy sources of funding will be developed to support the local model selected to deliver consultant led maternity, special care baby, inpatient gynaecology and related services on both sites in accordance with IRP recommendation 3.	• The East Sussex PCTs are currently in the final stages of setting their budgets for 2009/10. • The PCTs are committed to prioritising revenue resources against the implementation of this change of service.
R6	The Director of Public Health should, in consultation with clinical staff and service users, agree a set of audit measures to assess outcomes and quality of care which will be regularly monitored before, during and after implementation. These should demonstrate at least stability and preferably, improvement in quality of care and patient experience.	The metrics are being developed further and made more timely, PCTs Professional Executive Committees are monitoring the quality standards on a quarterly basis.	• The PCTs' Professional Executive Committees continue to monitor the quality of standards on a quarterly basis.
R8	The PCTs and Hospital Trusts should establish mechanisms to effectively involve service users and staff in design and implementation of any reconfigured maternity, special baby care and gynaecology services to ensure that the concerns of service users and staff are identified and addressed as far as possible.	Section 4 of the PCT Plan in response to the IRP recommendations sets out how we will work to involve patients, the public and other key stakeholders including staff. Several employees of the local NHS, have been part of the Maternity Strategy Group and have contributed to the ongoing development of the maternity services strategy. This work will now be taken forward by the wider stakeholder groups which will also look at the best way of communicating with staff groups	• The PCTs have established a Maternity Services Development Panel (MSDP) and Clinicians Forum to drive forward implementation of IRP recommendations. • The MSDP convened a collaborative design workshop to consult with panel members on an engagement plan. • The outcomes from this workshop culminated in the production of an engagement plan which is to be approved by the MSDP. The principles of engagement, tools, methods and approaches to ensure wide stakeholder involvement and the implementation of the IRP recommendation are set out in the plan.

	Recommendation	Last reported status **November 08**	PCTs' Progress report **March 09**
Recommendations relating to gynaecology			
R22	The PCTs should work with local GPs and the Hospitals Trust to ensure gynaecology care is provided in community settings or as day case procedures as far as is safely possible.	There is a national drive to deliver care closer to people's homes where appropriate and Practice Based Commissioning Groups and the PCTs Professional Executive Committees will look at options for this. The recommendation will also be taken forward as part of the wider work of supporting IRP recommendation 3.	• A Clinicians Forum has been established as a sub group off the Maternity Services Development Panel to advise on all clinical matters in relation to both the revised service model (incorporating a review of Gynaecology care in community settings) and the Maternity Strategy which will provide a framework for monitoring progress against the Maternity Matters action plan. • A number of clinical sub groups are being developed to take forward a review of each clinical area as part of an emerging network model, the links to primary care are considered vital to the formal or extended network. • There is good GP representation on both the MSDP and Clinicians Forum.
Recommendations relating to midwifery staffing (regardless of service configuration)			
R23	A plan for working towards 'Birthrate Plus' staffing standards should be agreed between the Hospital Trust and PCTs.	The draft strategy for antenatal, postnatal and community maternity services sets out the approach to midwifery manpower and makes recommendations on how this can be achieved.	• The revised Maternity Strategy (February 2009), endorsed at the meeting of the Maternity Services Development Panel on 5th March 09 sets out the approach to midwifery manpower. • A Birth rate Plus assessment has been completed and additional resource allocated to funding extra midwives. • The review of the midwifery workforce will form a key part of the maternity services workforce review and plan that is being led through the Maternity Services (IRP) Programme. • A work force sub group, one of the clinical sub groups linked to the clinicians forum will oversee the full review and supporting proposals to the Maternity Services Development Panel. The sub groups will be meeting during April, May and June 2009.

	Recommendation	Last reported status **November 08**	PCTs' Progress report **March 09**
R24	The PCTs should urgently undertake a review of community midwifery services, particularly the provision of ante and post-natal care in more deprived areas and the provision to support home births. They should produce and publish a plan for developing these services to be implemented alongside any reconfiguration of childbirth services.	The draft strategy for antenatal, postnatal and community maternity services will be available by 30 November 2008. It is intended that this will be shared with a wider range of stakeholders as part of the process set out in the PCT Plan in response to the IRP recommendations.	• The revised Maternity Strategy (February 2009) sets out the service priorities in relation to improving ante natal and post natal services. • A Maternity Strategy action plan is being developed and will combine the existing Maternity Matters Action Plan (incorporating targets for improving ante natal and post natal services) and the IRP Project Plan (focused on implementing the IRP recommendations). • Geographical working for midwives within the community setting is being introduced from April 1st 2009. Many GP's throughout the locality are supportive of 'open door' access to women living in the locality who may not be on their surgery list. In conjunction with establishing other, alternative venues for antenatal and postnatal service provision, e.g. ASDA Eastbourne and Children's Centres, this will ensure a greater number of community bases are available to deliver services which are easily accessible and convenient to women and their partners. It will also enable midwives to alter current working patterns to allow for greater equity amongst case-loads. • Posters highlighting direct access to midwifery services have been commissioned and will be displayed in a variety of venues across the locality. These will provide women with appropriate information about how to access a midwife and arrange maternity care, thus ensuring a first appointment with a midwife or an obstetrician prior to 12 completed weeks of pregnancy. • Around 400 women in East Sussex may require access to perinatal mental health services for treatment of

	Recommendation	Last reported status **November 08**	PCTs' Progress report **March 09**
			conditions such as depression, stress, anxiety during their pregnancy and post-natally. External funding from the Care Services Improvement Partnership has been obtained to implement a Perinatal Mental Health Network for Sussex – supported by a specialist midwife. The aim is to guide patients to the right service for the level of care needed and improve outcomes.
Independent Reconfiguration Panel (IRP) recommendations			
IRP 1	The IRP does not support the PCTs proposals to reconfigure consultant led maternity, special care baby services and inpatient gynaecology services from Eastbourne District General Hospital to the Conquest Hospital in Hastings. The Panel does not consider that the proposals have made a clear case for safer and more sustainable services for the people of East Sussex. The proposals reduce accessibility compared with current service provision.	In their Plan published on 3 October 2008 the two East Sussex PCTs confirm acceptance of this recommendation.	• The IRP recommendation to maintain consultant led services across the two hospital sites (Eastbourne District General Hospital and The Conquest Hospital in Hastings) forms a key part of the Maternity Services (IRP) Project Plan, approved by the Maternity Services Development Panel in February 2009. • Proposals to develop a model that retains this level of provision are being taken forward by the MSDP and Clinicians Forum. • The role of the Clinicians Forum is to make recommendations to the MSDP on clinically supported proposals. • A network model has been examined by the Clinicians Forum and an outcome from this initial work has culminated in the establishment of five clinical sub groups focused on service review, workforce, risk, safety and sustainability across all maternity services. • The outcomes from these sub groups will feed into and shape the evolving service model.

	Recommendation	Last reported status **November 08**	PCTs' Progress report **March 09**
IRP 2	The Panel strongly supports the PCTs decision to improve antenatal and postnatal care, and associated outreach services. These improvements should be carried forward without delay. (N.B this recommendation is similar to HOSC's R24 above)	In their Plan (para 2.4) the two East Sussex PCTs confirm acceptance of this recommendation. See also response to HOSC's R24 above.	• The 2 East Sussex PCTs are committed to driving forward improvements and the Maternity Services Development Panel endorsed the Maternity Strategy at their meeting on 5th March 09. • The Maternity Strategy sets out service priorities in relation to ante natal and post natal care. • The Maternity Strategy will be supported by an action plan that will combine the current Maternity Matters Action Plan and IRP project plan (incorporating key milestones and time frames for all service improvements). • Further to this the Clinicians Forum (the sub group off the Maternity Services Development Panel) have established a number of clinical sub groups incorporating a midwifery sub group that will be reviewing all existing services and developments. • The Maternity Matters group forms a key part of the performance monitoring framework and is linked into the Maternity Services (IRP) Programme.
IRP 3	Consultant led maternity, special baby care services, inpatient gynaecology and related services must be retained on both sites. The PCTs must continue to work with stakeholders to develop a local model offering choice to service users, which will improve and ensure the safety, sustainability and quality of services.	In their Plan (para 2.5) the two East Sussex PCTs confirm acceptance of this recommendation and pledged to work with stakeholders to do this. Section 4 of the Plan describes the approach to stakeholder engagement.	• The PCTs are committed to taking this recommendation forward. • For progress to date please refer to IRP1 and R8 above.

	Recommendation	Last reported status **November 08**	PCTs' Progress report **March 09**
IRP 4	The PCTs with their stakeholders must develop as a matter of urgency, a comprehensive strategy for maternity and related services in East Sussex that supports the delivery of the above recommendations. The South East Coast Strategic Health Authority (SHA) must ensure that the PCTs collaborate to produce a sound strategic framework for maternity and related services in the SHA area.	In their Plan (para 2.4) the two East Sussex PCTs confirm acceptance of this recommendation. The draft strategy for antenatal, postnatal and community maternity services will be available by 30 November 2008. Work is underway at the SHA to produce a strategic framework for maternity and related services in the SHA area.	• The revised Maternity Strategy (February 09) was endorsed at the meeting of the Maternity Services Development Panel on 5th March 2009 and will be considered by the Joint PCT Boards at end of March. • The strategy sets out the commitment to world class maternity services and the service priorities that support implementation of the IRP recommendations. • A network model is presented within the strategy as a way forward for ongoing service development and reconfiguration as part of the commissioner /provider framework. • The work being undertaken by the Clinicians Forum and the clinical sub groups will directly inform the scope of the network and further identify areas for ongoing development and improvement as part of the Service Level Agreement process.
IRP 5	The PCTs working with all stakeholders, both health and community representatives, must develop a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the Panel's recommendations.	In their Plan (para 2.2) the two East Sussex PCTs confirm acceptance of this recommendation. The Maternity Services Development Panel will be responsible for overseeing the wider engagement and communications strategy.	• The PCTs are fully committed to implementing this recommendation. • Progress to date is set out at R8 above.
IRP 6	Within one month of the publication of this report, the PCTs must publish a plan, including a timescale, for taking forward the work proposed in the Panel's recommendations	PCTs published 'Developing Sustainable Maternity and Associated Services: a plan for addressing the recommendations of the IRP' on 3 October 2008.	• Further to the publication of the plan for addressing the IRP recommendations on 3rd October 08 the MSDP has produced a Maternity Services (IRP) project plan. • The project plan sets out a comprehensive activities chart covering each IRP recommendation as a work stream with dedicated targets and key milestones. • The project plan is refreshed before each meeting of the MSDP and provides a system for accountability and reporting back to the project board on progress.

Draft maternity dashboard for FFF reconfiguration

Version 1.1, December 2008

	Indicator	Threshold	Site		2006/07 total	2007/08 total	08/09 Q1 Apr-08	08/09 Q1 May-08	08/09 Q1 Jun-08	08/09 Q2 Jul-08	08/09 Q2 Aug-08	08/09 Q2 Sep-08	2008/09 Year to Date	Comments
Service Delivery and Capacity	1) Number of unplanned obstetric unit closures	Zero	CONQ	n	29	49	6	1	3	1	7	1	19	There were two incidents in 2006/07 and two in 2007/08 when both units were on divert resulting in full closure
				Hours	237.9	548.0	46.0	5.3	27.3	3.1	51.9	4.8	138.3	
		Above monthly average for previous year	EDGH	n	24	25	1	0	0	2	4	3	10	
				Hours	202.3	228.6	17.7	0.0	0.0	14.6	34.2	25.1	91.5	
		Time on divert unavailable for at least one event	CBC	n	0	1	0	0	0	2	1	1	4	
				Hours	0	12.5	0.0	0.0	0.0	23.0	12.0	7.0	42.0	
	2) Consultant presence on labour ward (average weekly hours)	60+	CONQ		15	15	15.5	13.5	12.0	11.0	11.0	10.0	12	Taken from ESHT dashboard
			EDGH		15	15	11.0	10.5	8.0	12.0	11.5	10.5	11	Includes births C/S and ward rounds
		less than 40	CBC											
	5) Staffing - Midwife:birth ratio	1:28 or less	Whole trust				01:38	01:31	01:32	01:38	01:37	01:33		Taken from ESHT dashboard Not currently split by site
		1:35 or more												
	1 to 1 care in labour	TBC	CONQ											Desired indicator to be developed as part of maternity strategy
			EDGH											
			CBC											
	6) Paramedics (POET) trained	TBC	SEC AMB											To be updated once details received from SECAMB
Deprivation	1) % booked after 12 weeks	less than or equal to 10%	CONQ		26%	28%	23%	21%	25%	28%	27%	30%		Monthly data from ESHT dashboard for whole trust. Monthly site data will come through routinely from January 2009
		Greater than 25% (vital signs 08/09 target for PCTs)	EDGH		21%	23%								
			CBC		36%	40%								
	2) Additional support forms - n and % of total bookings	TBC	CONQ	n	221	248	29	21	18	16	14	23	121	
				%	11%	12%	17%	11%	12%	8%	7%	15%	12%	
			EDGH	n		111	16	18	10	15	10	18	87	
				%		5%	8%	10%	7%	8%	5%	9%	8%	
			CBC	n		18	0	2	1	1	2	0	6	
				%		2%	0%	3%	2%	1%	3%	0%	1%	
	3a) % smoking at conception	TBC	CONQ		39%	35%	36%	35%	30%	36%	35%	33%	34%	
			EDGH		28%	30%	34%	31%	31%	27%	28%	35%	31%	
			CBC		7%	11%	24%	13%	7%	18%	3%	12%	12%	
	3b) % smoking at booking	TBC	CONQ		28%	25%	30%	28%	17%	27%	28%	23%	26%	
			EDGH		19%	18%	20%	20%	21%	16%	16%	23%	19%	
			CBC		5%	7%	12%	9%	7%	14%	3%	12%	9%	
	3c) % smoking at delivery	Less than or equal to 15%	CONQ		26.8%	21%	27%	22%	15%	24%	22%	22%	22%	
		Less than 1% reduction on previous year	EDGH		17%	13%	18%	18%	20%	15%	15%	20%	18%	
			CBC		5%	8%	12%	9%	4%	14%	3%	4%	7%	
	4) Obesity - n and % of mothers with BMI > 30	*Consider national target for general population*	CONQ	n	332	311								Monthly data requested and will come through routinely from January 2009.
				%	17%	18%								
			EDGH	n	249	238								
				%	15%	12%								
			CBC	n	25	8								
				%	12%	2%								
	5a) Breastfeeding initiation	80%+	CONQ		70.3%	69.7%	75%	74%	75%	73%	74%	79%	75.1%	
		Less than 2% points above previous year	EDGH		75.9%	74.8%	76%	76%	69%	77%	83%	79%	76.9%	
			CBC		95.9%	93.7%	94%	100%	93%	86%	100%	100%	95.5%	
	5a) Breastfeeding at 6-8 weeks	TBC	CONQ			44.7%	51%	45%	44%	45%	40%	46%	45.0%	Experimental data extracted from
			EDGH			49.5%	49%	49%	46%	58%	49%	52%	50.8%	Community Child Health Systems
			CBC			72.8%	67%	60%	75%	85%	77%	85%	75.0%	
Outcomes	2a) Intervention rate - normal deliveries (babies)	Greater than or equal to 60% relates to Maternity Care Working Party definitions	CONQ	n	1,129	1,145	106	103	77	111	116	90	603	Definition not the same as
				%	64%	64%	61%	68%	54%	67%	67%	66%	64%	Maternity Care Working Party definitions
			EDGH	n	1,239	1,279	97	97	95	119	103	103	614	Definition on Euroking is women who have
				%	63%	64%	59%	66%	62%	64%	59%	61%	62%	a virginal birth where the baby is born head first
		TBC	CBC	n	314	317	17	23	28	31	26	27	152	and without the use of instruments
				%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	2b) Intervention rate - caesarean deliveries as a percentage of all deliveries (mothers)	TBC	CONQ	% elective c/s	9.0%	11.1%	11%	9%	11%	8%	5%	10%	8.9%	
				% emergency c/s	14.3%	12.3%	12%	9%	13%	9%	10%	10%	10.3%	
				% Total c/s	23.3%	23.4%	23%	17%	23%	16%	15%	20%	19.2%	
				Number of total c/s	404	414	42	26	33	27	27	27	182	
			EDGH	% elective c/s	12.6%	11.2%	13%	10%	10%	7%	13%	11%	10.5%	
				% emergency c/s	15.7%	15.7%	15%	11%	19%	20%	17%	19%	16.9%	
				% Total c/s	28.3%	26.9%	28%	21%	29%	27%	29%	30%	27.4%	
				Number of total c/s	543	531	45	30	44	51	52	51	273	

Update on the Family Nurse Partnership

The Family Nurse Partnership team was established in August 2008 and following the team's initial training the recruitment of families commenced 29th September.

The recruitment of families is going well and is on target (By May 2009 the team must have recruited 80 young mothers 20 years and under and 20 mothers between 20 – 22 years of age)

See table below for recruitment.

Month	Number of potential clients notified to FNP team	Number of clients recruited to FNP
Sept 2008	9	8
Oct 2008	10	8
Nov 2008	13	9
Dec 2008	12	9
January 2009		*Verbal update at HOSC*
February 2009		*Verbal update at HOSC*

- 5 parents have declined to take up the programme for a variety of reasons
- Two babies have now been born within the programme.
- Recruitment to the additional pilot project for first time mothers 20 – 22year olds has not been so easy. This is exactly the same for Islington PCT. However with persistence the team has been able to engage all of the eligible mothers
- The Programme has set clear criteria for this age group [Young people not in education, employment or training (NEET) and not in regular paid employment and/or NEET with no qualifications] for recruitment and both pilot sites have found that only using this criteria has presented challenges.
- There has been one incident for the local team of being unable to recruit a very vulnerable 20-22 year old mother because she **did have** qualifications, hence not meeting the criteria. In this instance and following a discussion with the FNP

supervisor the Project Lead took the decision to recruit this client. She is doing well within the programme.

- The decision to accept this client onto the programme was raised at one of the data reporting meetings with Birkbeck and the central FNP team.

- As a result of this East Sussex has been asked to do a further exercise around identifying specific mitigating factors that could potentially be used as broader criteria for this age group – either to be tested by subsequent pilot sites or to be considered as part of the roll out process for Wave 2 sites.

- It must be noted that the excellent partnerships that have been developed with local midwifery services has aided the smooth running of the recruitment process to the Family Nurse Partnership Programme

- Wave 2 sites have been advised by the central team that they can choose to continue to recruit to the programme (once the initial 100 clients have been recruited). There will however be no further funding from the DH to support this. ESCC and Hastings & Rother PCT need to consider this option.

Maternity Services Strategy

An outline strategic direction for East Sussex

2009 - 2012

Version control

Version	Author	Date
6.0	**J.Phaure**	**9.3.09** **Amended following the meeting of the Maternity Services Development Panel on 5.3.09**

Contents

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 Matters action plan (Appendix 1) 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 recommendations to be taken forward include:

- Developing a model of care that ensures the continuation of consultant-led maternity services, special care baby services and inpatient gynecology services in both Hastings and Eastbourne.
- Ensuring that improvements to antenatal and postnatal care and associated outreach services are implemented without delay.
- Developing further community outreach services, which will include health visiting and community midwifery, and ensure that these services are staffed accordingly.'
- Developing a strategy to ensure open and effective communication and engagement with the people of East Sussex in taking forward the IRP recommendations.

As the IRP programme is currently working on taking forward the model, in conjunction with the MSDP and Clinicians Forum (CF), there are key elements of the service model that are still under development. Further details and linked strategies

will follow, particularly in relation to the provision of obstetric, gynaecology, paediatric and neo-natal services in acute settings. In relation to community services the IRP programme is also focused on building stronger partnerships with primary care.

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"[1]. 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[2] 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*[3] 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 (Appendix 1). 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

[1] Department of Health, Health Reform in England: update and commissioning framework (2006)

[2] Department of Health National Services Framework for Children, Young People and Maternity Services (2004)

[3] Department for Education and Skills Every Child Matters: Change for Children (2004)

Making Normal Birth a Reality [4]whilst respecting women's individual needs and wishes.

The national choice guarantees

1.5 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
    - 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**

1.6 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

1.7 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[5].

1.8 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)[6] and demographic and lifestyle changes. At

[4] Making Normal Birth A Reality, Maternity Care Working Party, November 2007

[5] 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)

[6] HSC, Guidance on implementing the European Working Time Directive for Doctors in Training, January 2003

the same time, the principle should be that pregnancy and birth are normal life events supported by midwives.

1.9 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

1.10 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 (Appendix A). 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.

1.11 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.
- developing the monitoring framework for the future.
- delivering the national choice guarantee.

Consultation and engagement in the Strategy

1.12 As part of the development of this strategy the PCT's formed a Maternity Strategy Working Group. The purpose of the group was to prepare a three year improvement strategy 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.

1.13 The group made recommendations to the PCT Boards in relation to implementing the Boards' decisions on Antenatal, Postnatal & Community Maternity Services and in relation to the standards set out in national policy and guidance. These recommendations have been incorporated into an overall Maternity Strategy for East Sussex by the MSDP.

The Role of the Maternity Strategy Working Group was to:

- Determine priorities within the programme.
- Set objectives and agree targets and milestones for each workstream.
- Ensure appropriate engagement with stakeholders (including public and patient).
- Ensure effective project management of its work including quality assurance and risk management methodologies.

- Develop indicators to assess outcomes and quality of care and regularly monitor the programme to demonstrate improvement in quality of care and patient experience.

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[7] are met.

Governance

1.15 The working group was accountable to the Boards of the two East Sussex PCTs', and was chaired by the Interim Director of Development (East Sussex PCTs').

[7] 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[8] 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 4th 2008. The report made clear recommendations for ensuring the delivery of safe, sustainable services in East Sussex.

[8] 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 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, anesthetists 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[9] 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 Gyaenacologists, 2007)****:* We support the development of a comprehensive single set of standards covering the full maternity care

[9] HM Treasury 2004 Spending Review: Public Service Agreements 2005-2008 (2004)

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 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 20th 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.

Influences on current service provision

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 and local needs assessment

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

Infant mortality[10]

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.

[10] 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]

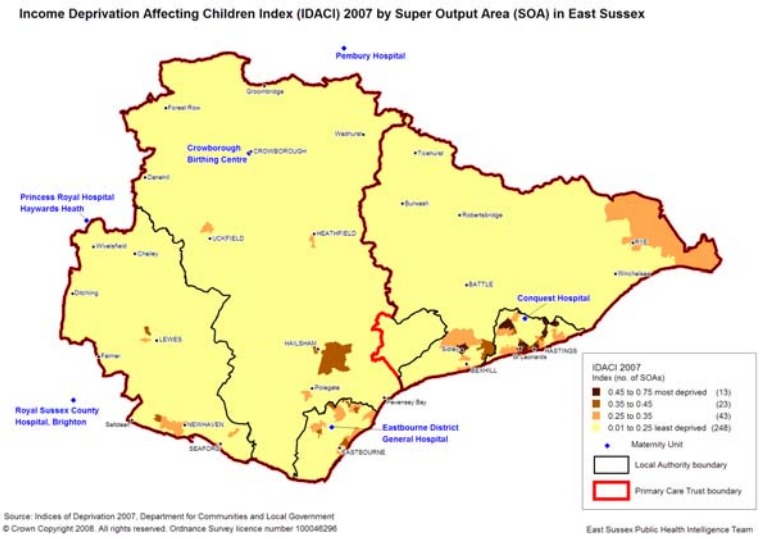
* Rate per 1,000 total births
** Rate per 1,000 live births
*** Rate ratio using least deprived as baseline
Source: Perinatal mortality 2005, CEMACH, April 2007

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.

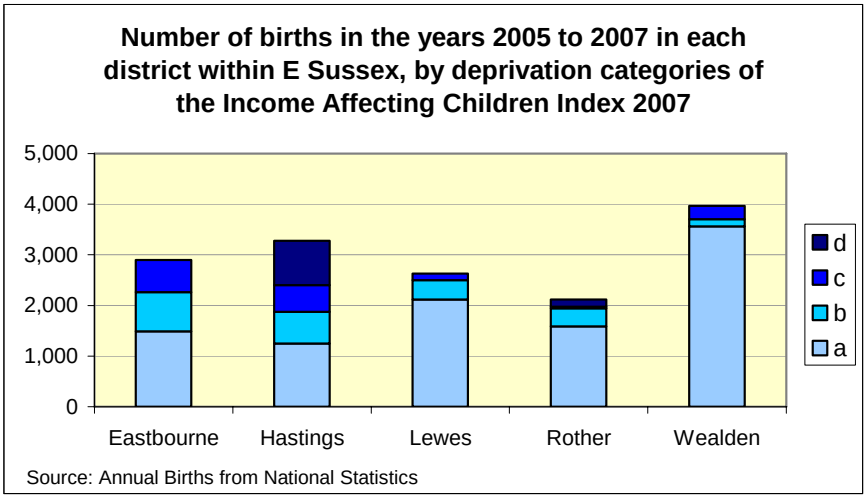
2.20 'East Sussex in Figures[11]' reports that 13 small areas in East Sussex (technically referred to as 'Super Output Areas') were in the 10% most disadvantaged areas in England, 12 of these are in Hastings. Altogether just over one-third of all the Super Output Areas in Hastings are among the 20% most disadvantaged in England: the borough has the most disadvantaged Super Output Areas of any area in the south east.

[11] East Sussex in Figures, http://www.eastsussexinfigures.org.uk/webview/



2.21 The Maternity Needs Assessment[12] 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.



[12] East Sussex Downs and Weald PCT, Maternity Services for East Sussex: Epidemiological Needs Assessment, Public Health

Markers of Deprivation				
	Pre-2006 PCT			
Census variable	Eastbourne Downs	Sussex Downs and Weald	Bexhill and Rother	Hastings and St Leonards
Non-white ethnic group (%)	2.6	1.9	1.9	3.0
Unemployed (%	2.4	1.9	2.3	4.1
No qualifications (%)	28.7	22.6	28.6	31.7
Lone parent households withdependent children (% households)	5.1	4.6	4.6	8.0
Owner occupied (% households)	75.6	79.6	78.0	63.6
Housing association (% households)	4.6	2.9	8.6	13.7
Have no car or van (% households)	26.2	15.7	20.5	33.8
Source: Census, 2001				

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.

Households with dependent children with no car or van				
	Couple family households	Number(%) No car or van	Lone parent family households	Number(%)No car or van
Eastbourne	6578	45(7%)	2473	976(39%
Hastings	7036	68(10)	2990	1492(50)
Lewes	7976	306(4)	1873	583(31%)
Rother	6232	17(3%)	1733	501(29%)
Wealden	12976	16(1%)	2405	430(18%)
Source: Census, 2001				

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.

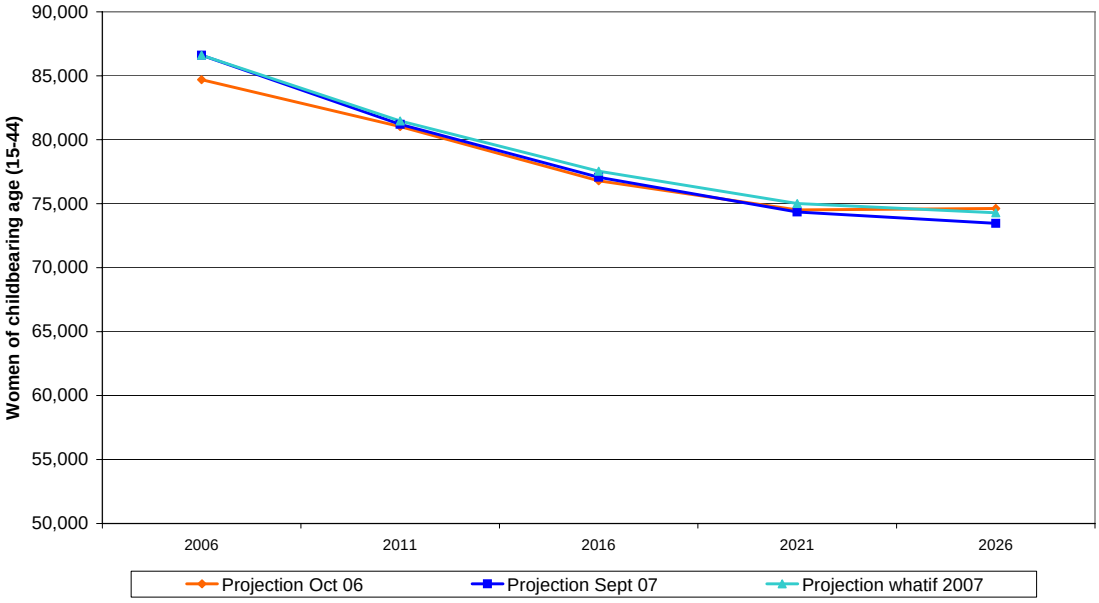
2.29 An estimated 83, 800 women aged 15 to 44 lived in East Sussex in 2005, accounting for 17% of the population.

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**
East Sussex		**497,900**		**83,800**	**17%**
East Sussex Downs & Weald PCT		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%
Hastings & Rother PCT		170,600		28,300	17%
Hastings B.C.		84,600		16,300	19%
Rother D.C.		86,000		12,000	14%
Source: National Statistics Mid-year Estimates 2005					

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).



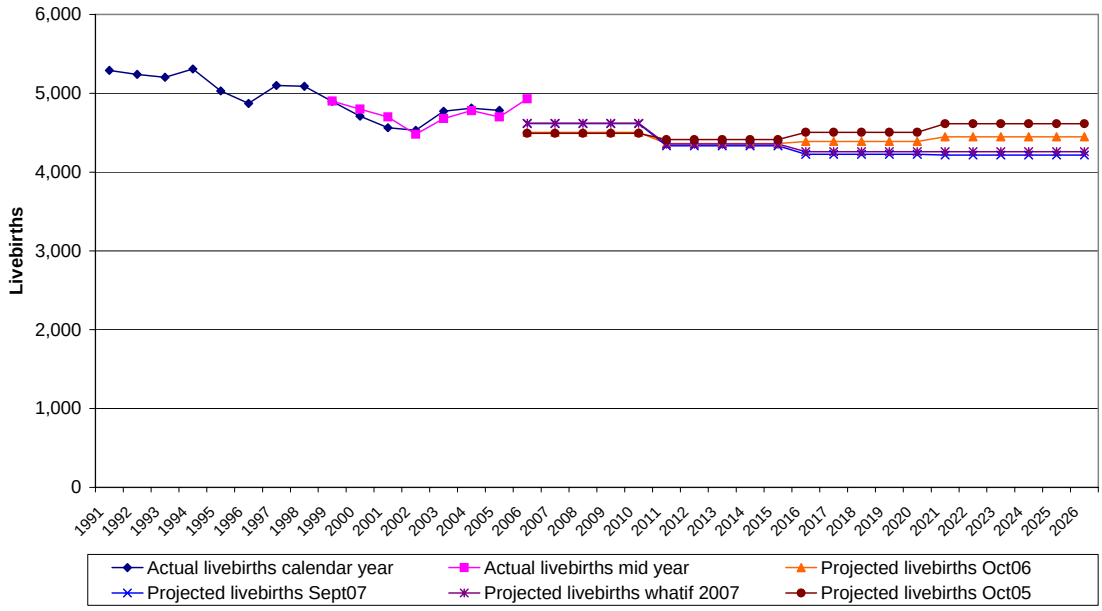
2.32 In understanding these projections it should be noted that overall population growth is expected to be 2.6% but this is mainly amongst older age groups (aged over 50). Households with a "head" over pensionable age are projected to increase by nearly 42% over the twenty years to 2026. Much higher 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, anesthetists, mental health practitioners, neonatologists or others, through maternity team care.

	No Births 2003-2005					% with birthweight below 2,500g					No. with Low Birth weight 2005-2007				
IDACI 2007	a	b	c	d	Total	a	b	c	d	Total	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 (EWTD)/level of specialisation required

2.39 The introduction of the EWTD has resulted in a reduction in doctors' hours contributing to a requirement for different ways of working to provide maternity care. Modernising Medical Careers[13] recognises these challenges and proposes a major reform of postgraduate medical education that aims to improve patient care by delivering a modernized 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.

[13] DOH, Modernising Medical Careers: the next steps, April 2004.

3 Choice, access and continuity of care

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

3.2 The majority of Eastbourne and Hastings residents give birth at Eastbourne District General Hospital, The Conquest District General Hospital or Crowborough Birthing Centre (facilities operated by East Sussex Hospitals) as do most Rother residents. Almost half of Wealden residents and most Lewes residents give birth elsewhere (Royal Sussex County, Brighton; Princess Royal, Haywards Heath; Pembury). Although not all women who need maternity services will choose to give birth in one of the facilities of East Sussex Hospital Trust, the two PCTs commission services for all residents. East Sussex Hospitals are a significant provider of antenatal and postnatal care in the community even for those women who choose to give birth in units outside the county.

Service priorities

3.3 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.

3.4 Maternity Matters Self-Assessment[14] 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.

3.5 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.

3.6 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.

3.7 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.

Service priorities, choice guarantees and expected outcomes

Choice/Service priority	Outcome
Providing antenatal and postnatal care in convenient community settings, ideally Children's Centres), at times convenient to women and their families.	• 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. • 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.
Assessing each woman's needs and then providing care	• All women will have a personal care plan reflecting their needs and choices.

[14] DOH Maternity Matters Self Assessment Tool Kit for commissioners, 2007

Choice/Service priority	Outcome
and support that meets those needs. This includes providing additional support for vulnerable women and their families.	• Universal antenatal care will follow the model recommended by National Institute for Health and Clinical Excellence (NICE). • Each woman's need for enhanced service will be assessed as part of the initial assessment. • 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.
Offering all women direct access to midwifery services	• Both antenatal and post-natal care will be directly accessible (i.e. without referral from a GP). • 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. • Ensure that all women have been assessed and provided with an individual care plan before 12 completed weeks of pregnancy. • 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.). • Innovative approaches will be developed to get this information to women (for example including information in pregnancy test kits).
Ensuring early assessment for all pregnant women	• 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. • An evidence based assessment tool will be used (soon to be piloted by NICE). • Not all women will access midwives directly. Some will visit their GP, and from there be referred on for maternity care. • Referral processes will need to be reviewed to ensure that they are efficient and timely to facilitating early assessment. • 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.

Choice/Service priority	Outcome
Supporting choice in antenatal and postnatal care	• Ensure that all women and their partners are offered a wider choice of type and place of maternity care and birth. • Information will be made available for women and their partners about the range of choices available to them for antenatal care and postnatal care. • 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. • 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.
Supporting choice for place of birth (home, midwife led unit or obstetric unit) and between team and midwifery led care	Depending on their circumstances, women and their partners will be able to choose where they wish to give birth. 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 the maternity team including midwives, anaesthetists, consultant obstetricians and paediatricians. For some women this will be the safest option. • We will ensure that women who want a home birth are supported in this choice. • 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.
Ensuring that women are not left alone during labour or birth	• 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, • Best practice for achieving this is still being defined nationally. The right number of midwives, appropriately deployed, will be key.
Making sure that we have the right number of staff with the right skills	• 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. • Ensure that the recommended number of hours of

Choice/Service priority	Outcome
	consultant presence is achieved on labour wards. ESHT will be asked to develop plans to achieve 40 hours. • The PCTs have made clear that unplanned diverts 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. • All women and their babies will receive treatment from health care professionals competent in resuscitation for both mother and infant, and in newborn examination.
Normal birth should be facilitated wherever possible	• 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. • 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). • 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.
Promoting and supporting breastfeeding	• Services will promote breastfeeding, whilst supporting all women whatever their chosen method of feeding. • 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. • 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. • 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

[15] UNICEF baby friendly initiative http://www.babyfriendly.org.uk

Choice/Service priority	Outcome
	Friendly[15], or other formal accreditation.
Ensuring that all staff are trained and competent in core maternity skills	• 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 will be maintained.
Offering high quality (NICE recommended) antenatal screening	• All women will have a personal care plan reflecting their needs and choices. • Universal antenatal care will follow the model recommended by NICE.
Identifying problems with maternal mental health and providing appropriate specialist care	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. 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. 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: o Access to a specialist perinatal mental health service with acceptable waiting times for referral. Midwives should be authorised to make referrals. o A review of their provision of specialist midwives for mental health needs. o Access to a psychiatric mother and baby unit providing care for mothers with serious mental health needs and their babies.

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 proposed 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 (Appendix 1). 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). Build on 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.

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[16]' 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.

[16] RCOG, Safer childbirth minimum standards for the organisation and delivery of care in labour, October 2007

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 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

Role	Funded WTE	Headcount
Midwife	131.3	165
Healthcare Assistant	28.3	36

(Source: ESHT ESR as of 31/8/08)

- **Birthrate plus calculations.**

4.15 Birthrate Plus is a nationally accepted tool for calculating the required number of midwives based on demand (births and casemix). 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. Measures are currently underway in 2009 to recruit additional community midwives.

- **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.

- **<u>The scope of the workforce sub group includes:</u>**
- 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 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.

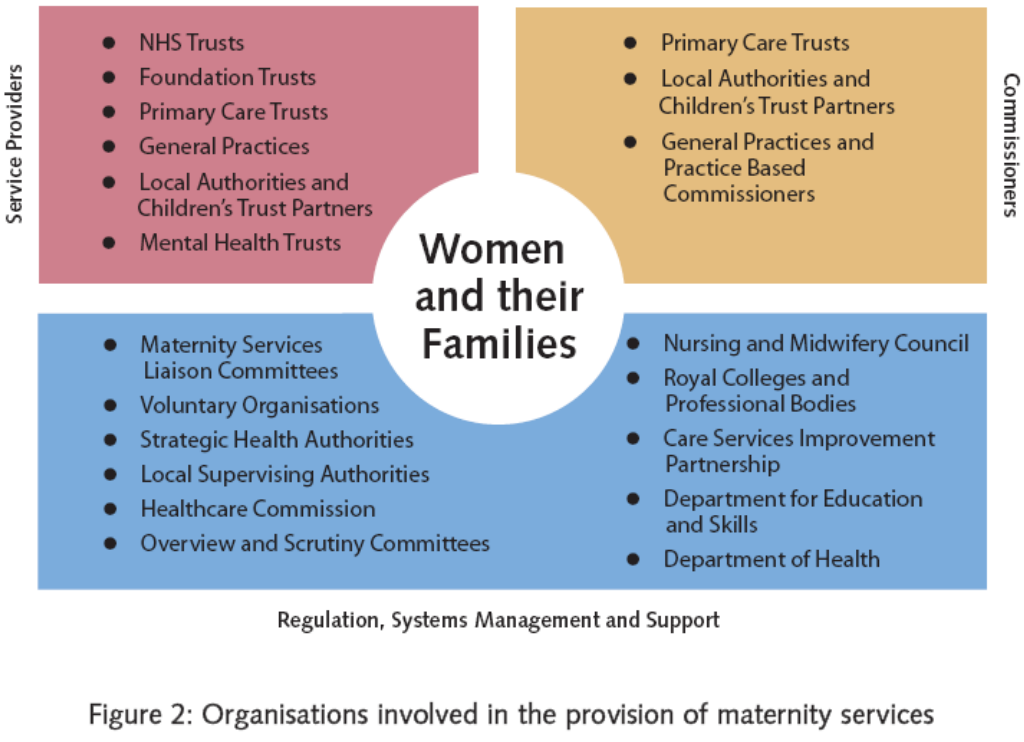


Figure 2: Organisations involved in the provision of maternity services

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.

Maternity Networks (East Sussex Downs and Weald and Hastings and Rother PCT)

1. Purpose and structure of the paper

The main purpose of this paper is to report back to the PCT Boards on the progress that has been made by the Maternity Services Development Panel and Maternity Services Clinicians Forum in exploring the suitability of a network model for East Sussex. The structure of this paper is as follows:

- **Section 2:** Presents the background to the IRP recommendation on developing a model that retains consultant led services across the two hospital sites. This section also examines the wider key drivers for change and policy context within which networks are evolving across the country.
- **Section 3:** Provides a summary of the outcomes from the discussions held at the last Maternity Services Development Panel and recommendations that were presented to the panel by the Clinicians Forum.
- **Section 4:** Provides a summary of existing networks in Sussex and introduces a definition of a managed network.
- **Section 5:** Provides good practice case examples of managed networks, setting out Terms of Reference, scope and broad principles (which could be adapted).
- **Section 6:** Sets out the possible next steps in taking a network model forward.

2. Background

The Independent Reconfiguration Panel (IRP) published its report on the proposed changes to maternity, gynaecology and special care baby services in East Sussex on September 4th 2008. The report made clear recommendations for ensuring the delivery of safe, sustainable services in East Sussex including:

- To improve antenatal and postnatal care and associated outreach services
- To retain consultant-led maternity, special care baby, inpatient gynaecology and related services across both sites. This included working with stakeholders to develop a local model offering choice to

services users, which will improve and ensure the safety, sustainability and quality of services.

The overarching aim for reorganising services is to improve the quality of service, concentrating on safety and working towards better outcomes and satisfaction, for all women and their babies. Maternity Matters and the RCOG paper on Maternity Services, future of small units, both recognise the range of pressures on existing services and drivers for change as follows:

- Maternity services must be appropriate for the 21st century and meet the needs of women and families
- Women and their partners want services that reflect their views and expectations
- Implementation of choice may increase the demand for homebirth and midwifery care
- There is a need to empower midwives to promote normal birth
- The changing profile of women who become pregnant has increased the number of women who may be considered high risk
- There is evidence that women with risk factors or complications may need expert care at any time of the day or night and that that care may be highly specialised
- Shorter working hours imposed by the WTD which significantly affect maternity services because there can be no cross-cover from another medical specialty
- Shorter working weeks can also make it more difficult for trainees and consultant obstetricians to obtain and maintain their skills to an appropriately high standard
- Ensuring financial affordability and value for money for the taxpayer
- The Public Service Agreement target to reduce infant mortality and childhood obesity
- Increasing demand for capacity as a result of the increasing birth rate
- Choice gives providers the opportunity to increase capacity to provide maternity services to women from outside their area.

Case for networks

The importance and value of managed networks has been identified by Maternity Matters, the Children's and Maternity National Service Framework. Networks allow for sharing of common pathways of care as well as managing capacity in a more efficient manner.

Reorganisation gives local managers the chance to develop local services that are fit to deliver 21st century care, and in different locations. Antenatal and postnatal care may be provided in community settings such as Sure Start Children's Centres but care that is more complex may be provided in a hospital within a local network. Reorganisation can offer the opportunity, using the existing infrastructure, to redesign services, which are responsive, flexible and meet the needs of the population, both as a whole and as individuals.

Networks provide the potential for hospital and community services to be more integrated and for resources to be deployed in a more efficient and equitable way. Aligning services within a network can help to reduce inequalities in service

provision and focus on those families that have the potential to be socially excluded e.g. teenage mothers. Sustainability of services and affordability are key to reorganisation issues.

3. Outcomes from the Maternity Services Development Panel

At the first meeting of the Maternity Services Development Panel (MSDP), held on 8th January 2009, Mike Wood (Chief Executive) gave a presentation on network models. The MSDP asked the Clinicians Forum to take forward work on this at their meeting on 12th February 2009.

The Clinicians Forum considered a number of key questions as follows:

- In assessing the efficacy of a network what criteria would you use?
- What opportunities could a network provide in meeting the following key challenges?
    - Consultant hours
    - European Working Time Directive
    - Implementation of Maternity Matters
    - Service standards, pledges and targets
    - Maintaining consultant and clinical skills
    - Maintaining effective training for all clinicians
- What would be the preferred form and function of a network
- Set out the pros and cons associated with each model
- Broadly define the scope of a network
- What would/could be the benefits associated with any reconfiguration that may arise as a result of the network
- Summarise the above into recommendations to go to the Maternity Services Development Panel

The outcomes from the work undertaken by the Clinicians Forum were positive towards a network model. The key messages from the Clinicians Forum to the Maternity Services Development Panel were that:

- Further work will need to be undertaken by Clinical sub groups into the scope and viability of a network model for East Sussex (incorporating training, education and workforce, review of anaesthetic services to O+G, neonatal services, midwifery and community services and consultant led services).

- The sub groups will be led by key representatives from the Clinicians Forum and will report back on progress to the next meeting of the panel.

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. This was seen as important in relation to buy in and ensuring self sustainability.

- 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). Develop a looser network with Brighton and Hove but with the scope for 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 multiple 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. Existing networks in Sussex

Development of networks in Sussex

At the last meeting of the Maternity Services Development Panel the Chief Executive of East Sussex Downs and Weald and Hastings & Rother PCTs' gave a presentation outlining the local context, drivers for change and possible network models. The Clinicians Forum has been asked to consider the viability of these options and identify one which may work best for the area.

It is useful to bear in mind some of the wider developments that are currently taking place around the development of Sussex wide clinical networks. The four PCTs that cover the Sussex population (East Sussex Downs and Weald, Hastings and Rother, Brighton and Hove City and West Sussex PCTs) recognise the significant contribution that clinical networks have made both in coordinating

and developing improved clinical services for patients and in advising PCTs on the strategic direction and future needs of those services.

Clinical networks currently operate within a number of specialties. These include:

- Sussex Cancer Network
- Sussex Heart Network
- Surrey and Sussex Neonatal Network

The Sussex Cancer Network (SCN) was established in 1996. It is a non-statutory organisation consisting of a set of collaborative partnership relationships and services that underpin and deliver cancer services. The relationships cut across organisational and professional boundaries, in the same way as a cancer patient's pathway. The structure needs explicit agreement because of the statutory nature of the constituent organisations involved. The formal structure enables the collaborative partnership of commissioners and providers (statutory, voluntary, patients and carers) to make collective decisions on the review, planning, and procurement of cancer services to deliver the NHS Cancer Plan to the population of Sussex.

The SCN is one of 30 cancer networks in England and one of three managed cancer networks within South East Coast Strategic Health Authority. The network covers the provision of cancer services from Rye to Worthing and Brighton to East Grinstead. It is based around the radiotherapy catchment population of the Sussex Cancer Centre (currently 970,000).

The work of the SCN includes actively seeking participation, in the development and monitoring of cancer services, from patients, carers, the voluntary sector, local authorities, the health care professionals working in the organisations above, the Brighton & Sussex Medical School, South East Coast Strategic Health Authority, Universities of Sussex and Brighton, Local and Regional (London and the old South and new South East Coast East Coast) Specialised Commissioning Groups, neighbouring cancer networks and other clinical networks in Sussex e.g. critical care.

The Sussex Heart Network is supported by the national Heart Improvement Programme. The cardiac networks have immense potential to improve the way that services are planned and delivered for both staff and patients. Bringing together clinicians, managers and commissioners the network sees the cardiac pathway as a whole and provides a powerful voice in the local health economy to enable frontline staff to secure the changes they need to deliver for their patients.

The Neonatal network operates across Surrey and Sussex. Its hub in Brighton provides a referral neonatal intensive care service for Brighton and East and West Sussex. The Trevor Mann Baby Unit is the hub of the neonatal network, which covers Eastbourne ,Hastings, Haywards Heath (Princess Royal Hospital), Crawley, Redhill and Worthing.

There are 21 cots on the Trevor Mann Baby Unit, including 8 currently designated for intensive care and 3 for high dependency.

The PCT's are committed to further exploring the development of clinical networks and would now like to further develop and support clinical networks, to expand and enhance their roles to further engage with clinicians in developing World Class Services for the population across Sussex and to inform the commissioning process. Many of the existing clinical networks have been set up on an individual basis with varying degrees of support. It is now proposed to formalize these arrangements, by agreeing terms of reference, accountability and governance arrangements.

5. Networks as a way forward

A managed clinical network can be defined as "linked groups of health professionals from primary, community, secondary and tertiary care, working in a co-ordinated manner, unconstrained by Professional, Provider or PCT boundaries, to ensure equitable provision of high quality and clinically effective services" (adapted from BMJ 2000; 321: 1152-3).

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.

Examples of networks

Mid Trent Region.

Within the Mid Trent Region, the Mid Trent Critical Care Network and Trent Perinatal Network have demonstrated the ability to provide many of the perceived benefits associated with network working. This has been achieved by the development and implementation of clearly identified organisational and communication structures allowing the involvement and engagement of a wide number of stakeholder across the whole health community. The Networks have a clear vision and yearly objectives to drive forward the development and improvement of quality services within the NHS environment. Service Improvement is integral to the work of the Networks, which enables the sharing of best practice and a whole systems approach to health care.

The introduction of "Commissioning a patient led NHS," where formal organisations are seen as primarily commissioning or providing services, has prompted the question of where networks, as virtual organisations, sit within new health care structures. Currently within the NHS East Midlands, the position of Networks is being reviewed against this commissioner/provider framework. Much of the value of the critical care networks is in working across organisational boundaries acting as a conduit between commissioners and providers.

NHS East of England, Maternity and Newborn Care, Clinical Pathway Group (a managed network)

In the East of England discussion between representatives of both the larger and smaller units reached consensus that working together could improve the management of demand within flexible catchment areas and allow a sharing of capacity problems. It was also agreed that, not withstanding the "Choice" agenda, clarity on the care offered at each unit should be given and promoted as follows:

- All units should offer safe high quality services for straightforward births and ante and post natal care to their local populations.
- The larger units should also offer safe high quality services for more complex births and ante and post natal care to the wider population where necessary.

To support this it was proposed that clinical networks between the larger and smaller units should be developed in a more formalised way. This would allow sharing of expertise between units to support care locally as well as improvements in the management of capacity. It was generally agreed that it would be helpful if the networks were formed within the existing boundaries of the neonatal networks. This would lead to the formation of Perinatal Networks within the region, bringing together maternity and neonatal services.

It was recognised that networks need to be appropriately resourced and supported if they are to work well, e.g. the neonatal networks and the cancer networks. Informal networks, whilst having the benefit of establishing closer working relationship between units for good clinical and educational outcome tend to be disadvantaged by lack of continuity.

In the East of England the focus of managed networks has been on:

- Establishment of standards for care and clinical governance arrangements
- Availability of expertise for unusual and/or challenging conditions
- Provision of safe high quality local services for straightforward antenatal and intra-partum care at home, in MLU's or obstetric units
- Sharing training and teaching programmes
- Improved management of demand within flexible catchment areas and integrated capacity planning.
- Easier two way referrals or transfers between units and from home
- Identifying areas of care that need to be targeted e.g. perinatal mental and social health issues, provision of care the disadvantaged women.

The underlying principles for the networks were described as:

- Being patient focused
- Being clinically based
- Increasing standards and quality of care
- Using shared guidelines and protocols
- Facilitating rapid and appropriate referral
- Addressing governance issues
- Being supportive

By developing the networks, the East of England perceived that pathways of care could be established to identify the best place for high risk women to be booked for delivery, yet allowing local delivery of antenatal care along agreed guidelines. For low risk women, the development of formal midwifery networks would allow increased choice for women about which unit they give birth in while having antenatal and post-natal care delivered locally.

Joint appointments or SLAs between the smaller and bigger units in special interest areas, e.g. in fetal medicine, were considered, to share expertise. This included areas such as maternal medicine where a visiting obstetric physician would provide outreach high risk maternal medicine clinics but book the women for delivery in the tertiary centre.

Trainees could also work across the smaller and bigger unit to avail themselves of the training opportunities as set out by the Advanced Training Skills Module (ATSM) requirement.

Bedfordshire and Hertfordshire Perinatal Network

The Terms of Reference for this network area (available on request) are useful for considering the scope of a managed network in East Sussex.

6. Conclusion and next steps

The next steps in taking a managed network forward were determined by the Maternity Services Clinicians Forum and Maternity Services Development Panel as follows:

- Taking forward further essential work in order to establish a baseline position on current services and the scope for improving arrangements through a managed network.
- Involving clinicians and managers in working through the detail around specific services, sustainability, risk and care pathways (across the sub groups previously described)
- Developing a vision of how the network model could work across Eastbourne and Hastings with the scope for developing an extended network with Brighton and Hove, in the first instance.
- Ensuring that all work is supported by robust risk assessment, service analysis and understanding of staffing levels, skills mix and training/education opportunities.

The sub groups will be meeting during April, May and June 2009 and will feed back to the Maternity Services Development Panel.

Item 5 - Appendix 6

Maternity Services (IRP) Programme

Engagement Plan

1. Background

The Independent Reconfiguration Panel (IRP) published its report on the proposed changes to maternity, gynaecology and special care baby care services in East Sussex on September 4th 2008. The report made clear recommendations for ensuring the delivery of safe, sustainable services in East Sussex. The 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 enjoys broad representation from clinicians, partner agencies, local voluntary and community organisations, public engagement bodies, interest groups and members of the public. Each representative on the MSDP, as part of the Terms of Reference, understand their wider ambassadorial and representative role facing both outwards, towards the public, and internally, towards all other clinicians and practitioners engaged in the delivery and planning of Maternity Services across East Sussex.

One of the major commitments within the IRP implementation programme and project plan is to ensure that proposals gain broad community and clinical support and best meet the needs of the local population. A key objective within the Maternity Services (IRP) programme is to work with all parties to ensure effective and inclusive stakeholder and public involvement throughout the programme and jointly develop an engagement and communication strategy.

This engagement plan recognises the responsibilities that PCT's have in relation to public engagement and consultation as set out in Section 242 of the National Health Service Act 2006.

In order to move this plan forward the MSDP convened a collaborative design workshop to provide the PCT, the project team and local partners with practical advice on public and community engagement in relation to implementing the IRP recommendations. The outcomes from the workshop have directly shaped this engagement plan.

2. Aims of the engagement plan

The broad aims of the engagement plan are to ensure that all stakeholders (external and internal):

- Receive regular updates on the work being undertaken by the Maternity Services Development Panel and Clinicians Forum towards implementing the IRP recommendations
- Have a range of opportunities, via existing networks, forums and public engagement processes to channel their input into the IRP implementation programme via their representatives on the Maternity Services Development Panel and Clinicians Forum.

3. Engagement principles

One of the key outcomes from the collaborative design workshop was a set of principles that would underpin the programmes approach to engagement. The principles included:

- Creating opportunities for enabling people to express their opinions in their own way
- Encouraging as a wide a contribution as possible via existing forums, processes and representatives
- Ensuring that any feedback is acknowledged and progress against input is provided
- Developing the role and contribution of clinicians, building on internal communication channels and processes.
- Providing regular and up to date information to the public, clinicians, accountable bodies and partner agencies in order to raise awareness
- Utilising the Maternity Services Development Panel and Clinicians Forum as a means of ensuring openness and accountability

4. Potential interest areas

The collaborative design workshop identified a number of key areas where the public and internal/external stakeholders would have a vested interest (this acts as a guide for shaping the types of communication and engagement that may be required), as follows:

- Developments and progress being made towards implementing the IRP recommendations
- Details on what the revised “service model” may look like and the potential impact on patient choice, safety and service sustainability
- Opportunities that may be developed to further improve or enhance existing services
- The scope and breadth of proposed service solutions including: hospital based services, community based and outreach services (i.e. ante natal and post natal developments), preventative services and the range of support services such as transport and education/training opportunities.

The more strategic interest points would include reference to:

- Public health needs as expressed through socio economic and demographic factors (particularly health inequalities and deprivation)
- Clinical safety and sustainability (the focus of the Maternity Services Clinicians Forum)
- Systems and resources (budgeting, workforce planning, training and Continuing Professional Development, resource allocation, skills mix etc).
- Governance and monitoring arrangements to ensure public accountability

5. Communication and engagement tools

The MSDP recognise the variety of existing internal and external processes for communicating. All channels will be fully utilised through the life of the Maternity Services (IRP) Programme and beyond as part of ongoing engagement with "the revised service model."

At the last meeting of the MSDP on 5th March 09 it was agreed that the full range of mechanisms for managing external and internal communications and engagement would be further developed in conjunction with those represented on the panel. This work will be taken forward by the Maternity Services (IRP) Project Team so that the range of engagement processes and tools can be set out in a final version of the engagement plan.

6. Accountability and assurance

It is proposed that the implementation of the Engagement Plan will be monitored through the MSDP, as project board for the Maternity Services (IRP) Programme. The MSDP will report on engagement to the Joint PCT Board, in line with the Terms of Reference, alongside other IRP recommendations.

The engagement plan forms a key part of the IRP project plan and progress will be monitored and reported against key milestones as agreed by the MSDP. All engagement activity will be recorded enabling a full analysis of progress.

7. Summary and conclusions

The proposed model for engagement is one that builds on the respective roles and responsibilities of all agencies and interested parties, thus promoting shared ownership and responsibility. Further work needs to be completed within the plan on more specifically defining individual roles and setting out proposed engagement activity, with the agreement of each agency/interested party.