Agenda Item 5

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**11th March 2010**
By:	**Director of Law and Personnel**
Title of report:	**East Sussex Maternity Services Strategy**
Purpose of report:	**To update HOSC on next steps with the finalised East Sussex Maternity Services Strategy and to consider the Committee's future role in monitoring progress.**

RECOMMENDATIONS

HOSC is recommended to:

1. **Agree that the Committee's future monitoring of progress should focus on key outcomes and quality indicators using the approach outlined in paragraph 3.3.**
2. **Request a monitoring report in September 2010 and on a six monthly basis thereafter.**

1. Background

1.1 In January 2009 the Maternity Services Clinicians' Forum and Maternity Services Development Panel were set up to oversee development of a new maternity strategy for East Sussex, to include a model for maintaining consultant-led services in both Eastbourne and Hastings as recommended by the Independent Reconfiguration Panel. Significant work was undertaken throughout 2009 to develop a comprehensive strategy with the engagement of key interested parties.

1.2 At its meeting in November 2009, HOSC considered the final version of the East Sussex Maternity Strategy 2009-12 which had already been supported by the Maternity Services Development Panel. The Committee endorsed the strategy, with the proviso that aspects relating to geographical working for midwives be moved into the strategy's implementation plan. HOSC also agreed to hold a seminar to enable the committee to explore various aspects of the strategy.

1.3 The Boards of NHS East Sussex Downs and Weald and NHS Hastings and Rother formally adopted the strategy at their meetings later in November 2009 (taking into account HOSC's comments regarding geographical working).

1.4 On 25th January 2010, HOSC held a maternity seminar where Members of the Committee met with representatives of NHS East Sussex Downs and Weald/NHS Hastings and Rother, East Sussex Hospitals Trust and the Maternity Services Development Panel. This seminar enabled HOSC to explore aspects of the strategy in more detail and to understand how it was being implemented. The detailed implementation plan was subsequently circulated to HOSC Members for information.

2. Latest developments

2.1 Now that the East Sussex Maternity Services Strategy 2009-2012 has been agreed (although acknowledging financial discussions are still ongoing), the focus has moved to its implementation and delivering the anticipated benefits for women and babies. The Maternity Services Development Panel plans to hold a final meeting in March 2010 where it will conclude its work. The implementation of the strategy will then be fully integrated into the normal commissioning and performance management processes of NHS East Sussex Downs and Weald and NHS Hastings and Rother, and implementation of specific aspects of the strategy will be overseen by relevant clinical groups.

2.2 At the maternity seminar held in January, HOSC noted that there are some outstanding issues to resolve, notably regarding the funding of the services and potential enhancements as mentioned above, and also improving communications. Mike Wood, Chief Executive and Lisa Compton, Director of Assurance and Engagement, NHS East Sussex Downs and Weald/NHS Hastings and Rother will be in attendance at the HOSC meeting to update the Committee on latest developments.

2.3 One of the key tools being used to monitor progress on maternity care is the maternity 'dashboard'. This draws together a range of indicators and information about the quality and safety of maternity services and the outcomes for women and babies. It enables progress to be tracked at a high level, and any key areas of concern to be highlighted so that action can be taken in response to problems. The latest dashboard is attached at appendix 1 for information.

3. HOSC's future role

3.1 Since proposals to make changes to maternity services were first presented to HOSC in March 2007, the Committee has invested significant time and resources in scrutinising these services. Much progress has been made, culminating in the agreement of a comprehensive Maternity Strategy which commands broad support from local clinicians and representatives of patients and the public. As outlined above, this has now moved into implementation.

3.2 HOSC's primary role is to ensure that health outcomes for East Sussex people are maximised and inequalities are reduced. In terms of maternity care, this role may now best be achieved by focusing ongoing monitoring on the key outcomes and quality indicators contained in the maternity dashboard. This will enable the committee to track progress and focus challenge on any areas of concern, whilst leaving detailed implementation of the agreed strategy to the professionals with operational responsibility. Moving HOSC's input onto this more strategic level will also enable the Committee to devote resources to scrutinising other health issues of importance to East Sussex residents.

3.3 An approach which would meet these objectives could be a six monthly monitoring report comprising:

- the latest maternity dashboard; accompanied by
- a concise narrative report prepared by NHS East Sussex Downs and Weald/NHS Hastings and Rother containing commentary on any areas of concern (e.g. 'red' indicators) highlighted in the dashboard and any other key developments HOSC should be aware of in relation to maternity services.

3.4 HOSC is recommended to adopt this approach and receive the first of these monitoring reports in September 2010.

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Appendix 1

Maternity Performance Dashboard

Month	Type	Number of indicators	Red	Amber	Green
Jan	Milestone	20	0	0	20
	KPI	29	14	2	13
Nov	Milestone	20	0	0	20
	KPI	33	12	6	15
Sept	Milestone	20	0	0	20
	KPI	38	12	9	17

Objective Aim: Develop and Implement Maternity Strategy

NHS East Sussex Downs and Weald/NHS Hastings and Rother PCTs have worked with key stakeholders to design a new service strategy following the Independent Reconfiguration Panel (IRP) decision to maintain consultant led services at both of the East Sussex Hospitals sites (Conquest at Hastings, and Eastbourne District General Hospital), and to improve the quality of both antenatal and postnatal care services. Targets and milestones link directly to the Healthier People Excellent Care (HPEC) pledges on improving Maternity & Newborn Care:

- 2011 90% of pregnant women will see a midwife within 12 weeks
- 2010 all women will be able to make an informed choice about place of birth
- 2010 there will be a consultant present on the labour ward for at least 40 hours of every week (based on units with fewer than 2,500 births per year)
- 2010 all women will be individually supported by a midwife,
- 2010 all mothers and babies will receive high quality postnatal care.

Objective Summary

The development and implementation of the maternity strategy has been a key objective for the PCT, and was approved at the November Board meeting.

In relation to performance indicators for this objective there are currently 14 KPIs (Key Performance Indicators) scored red. A number of specific issues are highlighted:

During the period Nov 2009-Jan 2010 the following indicators moved from either Amber or Green to Red:

% Booked – Crowborough Birthing Centre
% Booking – Crowborough Birthing Centre
% Smoking at Booking – EDGH (Eastbourne District General Hospital)
% Smoking at time of Delivery – EDGH
Breastfeeding Initiation – Conquest hospital

However, the following indicators moved out of Red to either Amber or Green:

Intervention Rates – at the Conquest hospital
% Bookings – at the Conquest hospital
Consultant Availability – at the Conquest hospital

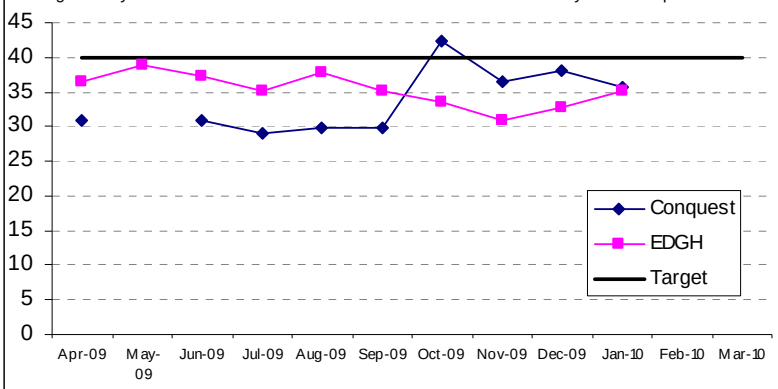
It should be noted that although there are 14 indicators that appear as Red, this is due to indicators being reported individually by each provider (EDGH, Conquest and Crowborough).

Consultant Availability on Labour Ward

The definition of consultant availability means that the consultant on call is within the hospital and would be immediately available for the labour ward when requested.

Consultant availability:

Average weekly consultant hours consultant available to attend immediately if/when required



Source: ESHT

Note: data for Conquest during May-09 not available

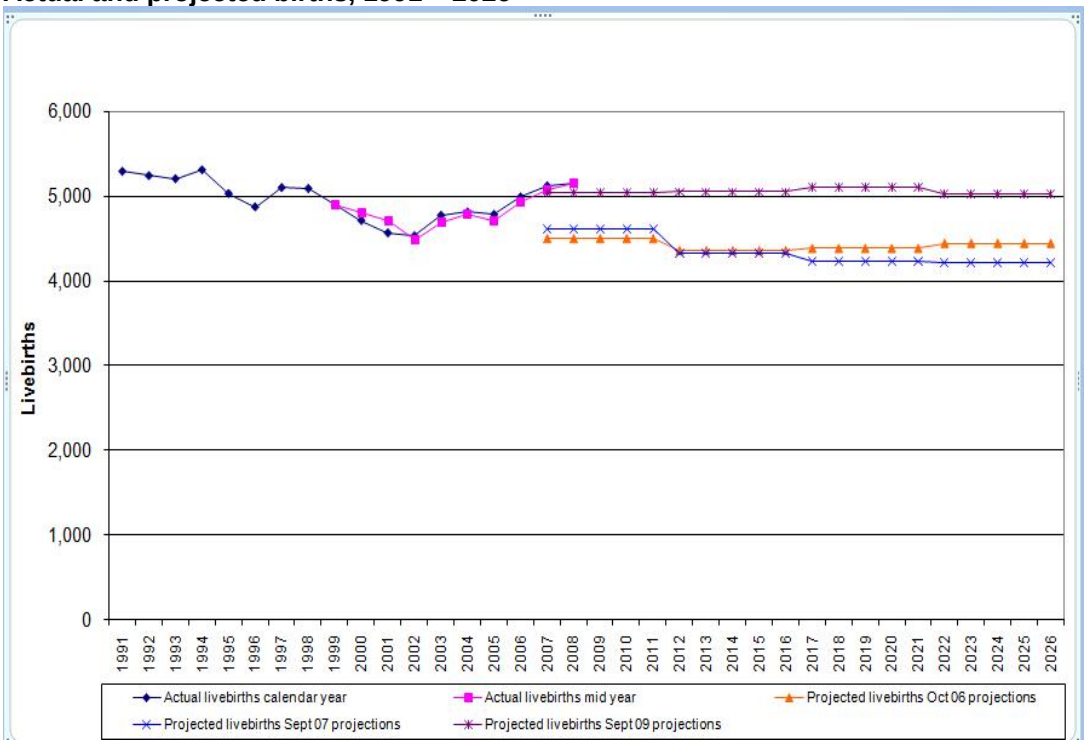
At other times the Consultant undertakes administrative or clerical work, Day Unit, Early Pregnancy assessment and teaching activities.

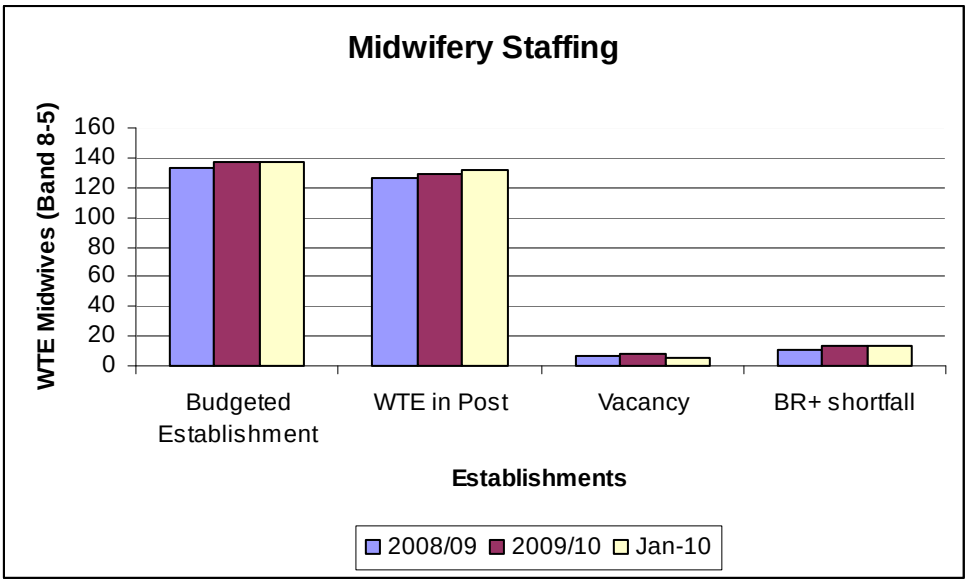
In January, the number of hours a consultant was immediately available was 36 at the Conquest and 35 at EDGH. Overall the trend is stable with improvements seen on both acute sites.

An additional consultant has been appointed as part of the European Working Time Directive. This is a cross-site post and this assists with increasing consultant immediate availability towards 40 hours for 52 weeks of the year. Note however, that there is always a consultant on call for 24 hours.

Midwifery Staffing: Birthrate Plus® is the recommended (and only accredited) workforce planning tool specifically designed for calculating the required number of midwives based on demand (births and case mix).

Actual and projected births, 1991 – 2026





(Information taken from East Sussex Hospital (ESHT) Midwifery Staff Lists 2008/09 & 2009/10)

The recommendation is that workforce planning is undertaken annually. Birthrate plus calculations have been undertaken for ESHT in 2004, 2008 and 2009.

Based on the Birthrate Plus® calculation undertaken in 2004, this highlighted a shortfall of 11.6 wte midwives. An additional 6 wte midwives were funded by the PCT in 2008 which reduced the shortfall to 5.6 wte. However, Birthrate Plus® was recalculated in June 2008. This resulted in an increase in the shortfall to 10.26. An additional 4 wte midwives were funded by the PCT in May 2009, reducing the shortfall once again to 6.26. Despite this when Birthrate Plus® was recalculated in July 2009 the shortfall has increased to 13.03 wte.

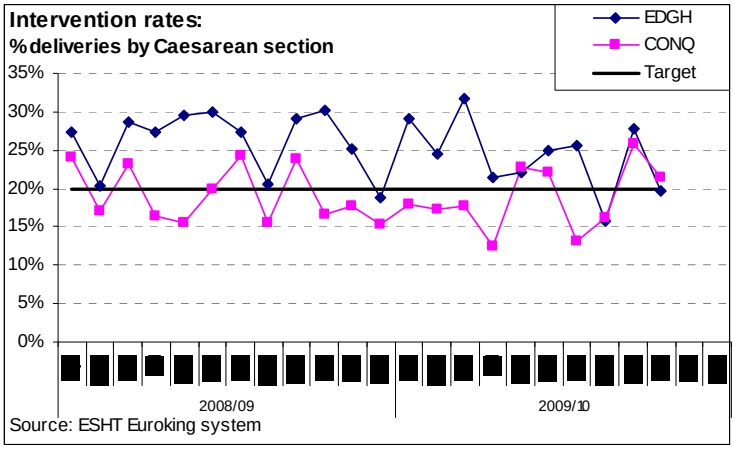
Without the initial investment of 10 wte midwives by the PCT during 2008-2009 the shortfall would have been 23.03. This seemingly large increase in deficit can be attributed to a combination of increasing birth numbers (and therefore midwifery activity) and the modification of the Birthrate Plus® formula to reflect the pledges of key policy documents which demand additional midwifery resource.

It is acknowledged that meeting Birthrate Plus® calculations is very challenging for many areas nationally. Locally a range of measures to ensure the most effective, innovative and productive use of resource is being considered.

Intervention Rates - % deliveries by Caesarean section

A monthly fluctuation in the number of bookings for maternity care and births within the maternity departments at EDGH, Conquest and Crowbrough Birthing Centre influences the % of births by caesarean section and is evident from the peaks and troughs shown in the chart below. Since the last Board report there has been an increase in the % of caesarean sections at the Conquest, reaching 21.3% in January. This can be attributed to the significant increase in elective caesarean sections during December.

At Eastbourne DGH the caesarean section rate has seen a dramatic reduction from 27.7% in December to 19.6%. This is now just below the target of 20%.



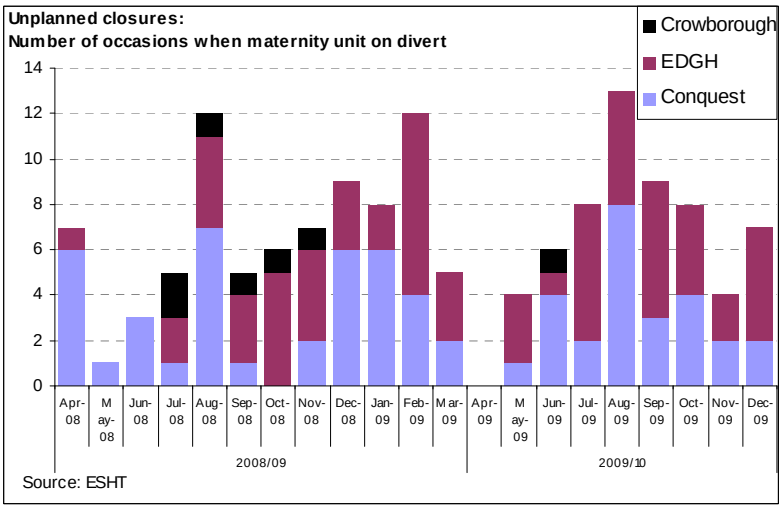
Initiatives to reduce intervention rates are an ongoing priority within ESHT and form a key part of the Maternity Strategy. It is anticipated that maintaining a continued focus on "Making normal birth a reality", future reports will see a more permanent downward trend.

Unplanned closures of maternity units

Since the last Board report, detailed discussions have taken place between ESHT and the Primary Care Trust regarding the CQIN (Commissioning for Quality and Innovation) target set for unplanned diversions of the maternity units. Diversions are now reported only when women in labour are not able to be seen and assessed in one or other maternity unit and therefore have to be transferred.

There was only one occasion, in November that both units had to divert at the same time. This resulted in an unplanned closure.

It is important to acknowledge that women are informed, when they contact the labour ward that the unit is being diverted and are asked to attend the nearest maternity department (usually pre-arranged by a midwife on duty). However, if a woman arrives unexpectedly, she is always seen and assessed on site. Women are not routinely transferred in labour unless they require specialist intervention.



Summary

Consultant availability on Labour Ward – to note the trend in relation to consultant labour ward availability in line with HPEC pledges.

Intervention rates – Despite the slight increase in caesarean sections at the Conquest site during the reporting period, the Board are asked to note the overall reduction in the number of caesarean sections undertaken. The Maternity and Newborn Clinical Implementation group will assume responsibility for managing the ongoing monitoring of intervention rates across both sites.

Unplanned closures/diverts - to note the plans for better utilisation of midwifery resource as part of the maternity strategy implementation plan and the normalising childbirth agenda. This will be taken forward as part of the maternity and newborn clinical sub group.

February 2010