East Sussex Health Overview and Scrutiny Committee

Report on the provision of Maternity Services by

East Sussex Healthcare NHS Trust

September 2016

A review of the midwifery services at East Sussex Healthcare NHS Trust (ESHT) was conducted between September 2015 and January 2016 to support the development of a vision and strategy for the maternity service and a model of care for midwifery practice. It was agreed an evidence-based improvement technique would be used, in order to maximise the opportunity for successful and sustainable changes to the service and to have a framework for spreading improvement activity more widely within the trust. A key focus for the review was developing an understanding of the experiences of both the people who use the maternity services and the staff who work in it.

There was project support from service users, members of Crowborough Birthing Centre focus group, former focus group members from Eastbourne DGH and the Maternity Service Liaison Committee (MSLC). They all contributed to the design and piloting of the tool to capture users' experience.

A key focus for the review was developing an understanding of the experiences of both the people who use the maternity services and the staff who work in it. The principles underpinning the review were:

- Listen and learn
- Understand *what we do well*
- Any changes must work well for service users and staff

Our maternity vision links to the trusts overall vision, this is:

To provide a high quality, sustainable maternity service and be the local provider and employer of choice. A maternity service which is safe, clinically effective and results in a positive experience.

1. Introduction

1.1 The purpose of this paper is to update East Sussex Health Overview and Scrutiny Committee (HOSC) on the improvements in performance, activity and quality achieved by East Sussex Healthcare NHS Trust (ESHT) maternity services since the reconfiguration of our services and to describe the challenges for our maternity service provision and how we are addressing them. Our maternity service review has informed this paper. We have an agreed Maternity Strategy and Maternity Service Specification (developed through staff and wider stakeholder engagement, including maternity service users) that clearly defines how our vision for a high quality, safe and clinically effective service that provides a positive experience for all users of our maternity services will be turned into reality.

2. Background

2.1 At ESHT we provided care for 3341 births during the financial year 2015/16. In addition, we also provided antenatal and/or postnatal care for women who chose to birth at an alternative provider.

2.2 In accordance with recommendations from the national maternity review *Better Births*, we are proud to offer women and their families a range of choices for their care. We provide community based midwifery services across our catchment area; a midwife led unit of 3 birthing rooms and 5 inpatient beds at the Eastbourne DGH; a consultant led unit of 10 birthing rooms, 14 antenatal beds and 23 postnatal beds at the Conquest Hospital. The birthing rooms at the consultant led unit can be used for midwifery led care. We offer full obstetric and midwife outpatient services at Eastbourne DGH and at the Conquest.

Table one below outlines the maternity services ESHT provides:

Eastbourne DGH	Conquest
Ultrasound	Ultrasound
Day Assessment Unit (with obstetric support)	Day Assessment unit (with obstetric support)
Consultant led Antenatal Clinic	Consultant led Antenatal clinic
Telephone Triage (Mon-Fri 8.30-19.00)	Telephone Triage (Sat Sun and from 19.00 to 08.30 Mon-Fri)
	In-patient antenatal care
Community based midwifery antenatal and postnatal care	Community based midwifery antenatal and postnatal care
Midwife-led birth centre	Consultant led Delivery Suite
Homebirth	Homebirth
Hospital based midwife-led postnatal clinics	Hospital based midwife-led postnatal clinics
	Level 1 special care baby unit (SCBU)

Women are able to make decisions about their care during pregnancy, during birth and after their baby's birth, through an ongoing discussion with their healthcare professionals. A named midwife (usually based in the community) coordinates care. Each woman will develop a personalised care plan with her midwife, based around care that is right for them, their family and their circumstances. Unbiased information forms the basis of discussions and a health and risk needs assessment is carried out at each contact. This assessment also determines who is the most appropriate lead professional (midwife, obstetrician or more specialist referral). Where more complex care is recommended, an obstetrician (and/or other specialist) will advise in drawing up the plan. Access to specialist care is available whenever needed.

Choice of place of birth is part of a more detailed assessment (between 34 to 36 weeks) to include individual preferences and health decisions about a range of aspects of care. The safety of mother and baby are paramount and form the basis for this assessment. We currently offer three options for place of birth:

<u>Home birth</u>

Women at low risk of complications can choose to give birth to their baby at home. Once established labour has started a midwife will care for the woman at home throughout the labour, with a second midwife attending to be present at the birth. If access to specialist services is necessary at any stage, a paramedic ambulance will be called and transfer made to the nearest obstetric unit.

Midwife-led Unit (MLU)

Women are able to choose to give birth to their babies at our MLU if their pregnancy has been uncomplicated**.** Women can choose to birth at the MLU if:

- They are between 37 and 42 weeks along in your pregnancy
- They are between 18 and 40 years of age
- They have had no complications in a previous pregnancy
- They have no complications in this pregnancy
- Their body mass index (BMI) at the booking appointment was between 18 and 35
- The baby is lying head down
- They are carrying a single baby in this pregnancy

Women who wish to deliver at the MLU are fully informed of transfer rates and outcome when they make their decision. We continue to operate on an opt in basis after a detailed risk assessment and informed discussion

Any risk factors that develop during the pregnancy may require assessment by a consultant obstetrician either at the Consultant Unit or in antenatal clinic or day assessment unit at Eastbourne DGH or Conquest Hospital. This may mean that birth at the MLU is no longer the safest option. Plans will then be discussed for birth to take place in a consultant led unit such as at Conquest Hospital.

The majority of women that come to a MLU in labour will successfully give birth there more than 60% of women with their first baby and over 90% of women who have had a baby before make up this success rate. Midwives are trained to monitor mothers and babies closely throughout their labour and birth and if there is any concern during labour or immediately after birth, for mother or baby, arrangements would be made to transfer to the appropriate consultant led obstetric unit immediately via a paramedic ambulance service. . In 2015/16 only 10 women (8%) were transferred in the second stage of labour, of the women who started labouring at the MLU, although delivery was still not imminent.

Research findings from the Birth Place in England Study 2011, which studied more than 62,000 women with a straightforward pregnancy, found:

- MLUs are just as safe as hospital for ‘low risk’ women
- Women who give birth in an MLU are more likely to have a straightforward birth with less medical intervention (such as caesarean or instrumental birth)
- Women who give birth in an MLU are more likely to be satisfied with their birth experience and are also more likely to breastfeed successfully

Our own data since May 2013 of 822 births mirrors these findings.

Consultant Unit

Women who have certain medical conditions or who develop complications during their pregnancy for themselves or their baby are advised to give birth in our Consultant Led Unit at the Conquest. Here, doctors are available 24 hours a day. They are able to perform epidurals for pain relief, assisted and emergency births and there is a Special Care Baby Unit (SCBU). Babies born before 32 weeks at the Conquest may need to be transferred to a regional specialist unit where specialist neonatal services are provided.

Women with uncomplicated pregnancies can choose to birth at a consultant unit too and there is a new Water Suite which provides a homely environment within the central delivery suite

2.3 Our Trust was inspected in September 2014 and again in March 2015 by the Care Quality Commission (CQC) as part of their national mandate to assess the quality of NHS organisations.

2.4 We are pleased that the CQC inspectors found that services across our Trust's maternity services were caring, and rated this aspect of our care as 'Good'. The CQC reported that throughout the inspection our staff were seen to treat service users with compassion, dignity and respect. The CQC said it was clear that staff were very committed and caring and did their best to achieve the best outcomes for our service users. As a Trust we are very proud of our marvellous midwifery and maternity services teams.

2.5 The CQC's reports raised some serious concerns and highlighted a number of areas where significant improvements were required in four of our clinical areas, including maternity and midwifery services. We have accepted these and are determined to resolve the issues. On the basis of the CQC's report, NHS Improvement (formerly the NHS Trust Development Authority) placed our Trust in 'special measures'. This means that the Trust will receive extra help and support to make the necessary improvements to our services.

2.6 To address the identified issues and challenges we have set up and are progressing a major programme of work, ESHT 2020, to ensure that we can consistently deliver the high levels of responsive, effective and compassionate care that we aspire to. A component of this work is a time limited Maternity Operations Improvement Project chaired by a member of our Trust Board. Through this project we have already addressed a number of urgent issues and are seeing visible improvement in our maternity services provision.

2.7 Key findings from the inspection were reported in relation to five categories:

Safe

- Midwifery staff shortages
- The movement of midwives from other sites resulting in temporary closures of Crowborough Birthing Centre
- On-call compensatory rest time
- No supernumerary labour ward shift co-ordinator

- Incidents not reviewed in sufficient depth or information shared to enable lessons to be learned.
- Failure to respond to trust guidance on electronic fetal monitoring

Effective

- Use of evidence based guidelines
- Low levels of women having normal births at the Conquest
- Lack of a consultant midwife to promote normal birth

Responsive

- Access to services
- No dedicated midwife-led facilities at the Conquest
- Disjointed pathways of care

Caring

- In most cases staff were:
- kind and helpful
- Providing reassurance
- Supportive of women's plans for labour and birth

Well-led

- Missed opportunities for engaging and involving staff in developing the service
- Lack of vision and guiding values
- No clear strategy and long term objectives Lack of leadership support
- A defensive culture

2.8 Recommendations for improvement following the inspection included:

2.8.1 Developing a clear vision and strategy for maternity services in collaboration with staff and service users:

- A clear vision has been developed and the strategy is in final draft

2.8.2 Ensure there is adequate staffing and leadership including managers, Consultant midwives and labour ward coordinators to meet the recommendations of the Royal colleges:

- The CQC identified that our maternity leadership needed to be strengthened and we recognise that the promotion of an energized and dynamic workforce that supports and challenges clinical decision making requires strong leadership.We now have a strong team in place with KPI's addressing specific areas such as promoting normal birth and ensuring all guidelines are up to date and evidence based.

- We have successfully recruited all our student midwives who are qualifying this month. We offer a strong preceptorship programme to support newly qualified midwives which has attracted our own students as well as students from other trusts.

- The transfer of staff from Eastbourne Midwifery Unit has been addressed. To ensure the quality of care is not compromised the matron of EMU works clinically when a member of staff's place of work has to be transferred. Transfer of staff is usually due to unscheduled sickness at the consultant led unit and EMU staff have been asked if they would like to be informed before they come on duty or when they arrive on duty. Transfer of midwives only happens after the request is escalated by Matron and all efforts are made to keep this to a minimum.

- The trust is committed to strengthening clinical leadership in all areas. There has been a revision of the remit of the medical leaders and this will enable appropriate time to achieve objectives. The new Chief of Division and General Manager for the Women's, Children's and Sexual health division will have clear objectives and responsibility and defined pathway to provide assurance and escalate issues to the Executive Directors and Trust Board.

- Since the CQC inspection identified the workforce issues within our maternity services we have undertaken much good work to address staff vacancies including the overseas recruitment of qualified staff.

2.8.3 Improve the environment for low risk women giving birth at the Conquest to ensure that normal birth is actively promoted.

- Refurbishing the Water Suite at Conquest which reopened in December 2015. From January 2016 to August 2016 there were 64 water births. We have improved our supply of birthing aides such as birthing mats and balls

2.8.4 Review staffing arrangements for community midwives to make sure that they are compliant with working time regulations:

- To provide continuity and availability of our community midwives to support our home birth service, we have currently conducted a pilot on community on-call service. The proposed changes will introduce a night shift for community midwives and an on-call service covered by all midwives.

2.8.5 Improve the way handovers are managed on Delivery Suite:

- SBAR (Situation, Background, Assessment, Recommendation) tool is used for all handovers
- Multi-disciplinary team handover over at 08.30 on delivery suite
- Handover led by the Consultant covering delivery suite

2.8.6 Ensure all women receive one to one midwifery care in labour:

Table 2 shows our compliance with the national recommendation for every woman in established labour to received 1 to 1 care. The table shows the compliance for the Consultant led unit at the Conquest Hospital.

Table 2 - 1 to 1 care from April to August 2016

Month	%	National recommendation
April	89	100%
May	91	
June	87	
July	85	
August	90	

- The above table shows that we did not comply with the good practice standard for 1to1 midwifery care for all women birthing at our Conquest unit during the months of April to August 2016.

- Women who birth at the Eastbourne Midwifery Unit do receive 1 to 1 care 100% of the time.

2.8.7 Improve the facilities and pathway of care for families with pregnancy: loss

We have introduced a new post 'Specialist Midwife Bereavement'. Their role is to ensure there is a seamless pathway of care for women who suffer pregnancy loss.

2.8.8 Improve breastfeeding support:

- We are working towards achieving UNICEF Baby Friendly status. To support this ambition we have: recruited an Infant Feeding Specialist Midwife; ensured that all newly recruited midwives, nurses working in our maternity units and maternity support workers receive training in supporting a woman to feed her baby, thereby ensuring that consistent information and advice is offered.

2.8.9 Consider the needs of vulnerable groups of women and babies and provide resources to meet those needs:

- We are in the process of recruiting a teenage pregnancy midwife

- We have introduced new specialist midwife posts for perinatal mental health, infant feeding, bereavement support and planned caesarean section.

2.8.10 Provide resources to accommodate the needs of women in early labour, where repeated journeys between their home and hospital may be advisable:

- We now support women and their partners who are admitted overnight in the latent phase of labour and do not wish to return home, by providing a single room for them to rest in on both sites. This initiative will be supported by a latent-phase care pathway which is being developed and will be completed by the end of September.

  We are particularly proud that we have increased capacity and improved patient flow by: Reviewing our guidelines relating to transitional care, management of newborn hypoglycaemia and abstinence scoring. This work has impacted positively on length of stay.

- Introducing an Enhanced Recovery following Caesarean section (ERAS) programme which has decreased length of stay following LSCS by 33%. Although capacity issues do sometimes arise these are managed by expediting the discharge process of women and babies who are fit to be transferred to community care.

- Training midwives to undertake a newborn medical check which has reduced the length of time women wait to be transferred home.

2.9 The remainder of this paper will present all of our progress made in our maternity services provision to date as well as set out our plans to address the areas of concern which are on-going. Identified areas for improvement have been grouped into the following key themes:

- Clinical performance
- Stakeholder engagement
- Leadership
- Workforce
- Clinical Governance
- Environment

KEY THEMES

3. Clinical performance

3.1 Achievements

3.1.1 Through the strengthening of our maternity care pathways we aim to ensure that all women have a safe, clinically effective and positive experience[1] when using our maternity services.

3.1.2 Table 3 shows the spontaneous birth rate achieved at ESHT April 2012-13 to March 2016 compared with the national average in 2013-14.[2]

ESHT Apr 2012- Mar 13	ESHT Apr 2013- Mar 14	ESHT Apr 2014- Mar 15	ESHT Apr 2015-Mar 16	National average 2013-14
59.4%[1]	59.8%	61%	63.2%	60.9%

The birth rate achieved by our maternity services is comparable to the national average.

[1] These are the standards set out in the National Maternity Review: Better Births, Improving outcomes of maternity services in England, A five year forward view for maternity care, Cumberlege J (2016)
[2] Hospital Episode Statistics, NHS Maternity Statistics – England, 2013-14, Health & Social Care Information Centre (January 2015)
[1] Health & Social Care Information Centre online statistics

3.1.3 Table 4 shows selected variables pre and post reconfiguration of maternity services at ESHT. The temporary reconfiguration took place in May 2013 and was confirmed in September 2014. The data is set in the financial year.

Table 4: selected variables pre and post reconfiguration of maternity services

	Apr 2012-Mar 2013	**Apr 2013 – Mar 2014**	**Apr 2014 – Mar 2015**	**Apr 2015 – Mar 2016**	**National average 2014-15**
Consultant presence on Obstetric labour ward	56 hrs per week	72 hrs Per week	72 per week	72 per week	Min 68hrs per week[3] recommended
BBA Births Before Arrival	11	27	34	45	n/a
Transfers	10	5	0	0	n/a
Diverts	46	7	28	18	n/a
Midwife to birth ratio	1:29	1:27	1:27	1:29	1:30
Total C-section rate	23.1%	22.9%	23.5%	24.2%	26%[4]
Elective C-section rate	9.8%	10.3%	10.4%	10.6%	11%[5]
Emergency C-section rate	13.4%	12.6%	13.1%	13.6%	15%[6]

The above table shows that our current midwife to birth ratio and Caesarean section rates are comparable to or better than the national average. In addition we are achieving a greater obstetric consultant presence on our labour ward than the minimum recommended to achieve good practice. Further information on BBA's is outlined below in point 3.2.3.

3.1.4 During their inspection of our maternity services the CQC identified issues relating to examples of non-compliance with the Trust's pre-eclampsia and use of syntocinon guidelines. We have ensured that all of our guidelines are evidence based and compliance is monitored through audit. The rationale for any variation from the relevant guideline based on the clinical situation of individual cases will be clearly documented in the woman's clinical record.

3.2 <u>On-going work</u>

3.2.1 Since April 2015 babies born before arrival[7] (BBA) have been classified as being either 'avoidable' or 'unavoidable'. By this measure we have reported a total of 67 BBA events of which 66 were classified as unavoidable and one was classified as avoidable caused by a delay in advising the woman to come into the hospital. The member of staff concerned received feedback from the Head of Midwifery.

3.2.2 Women who have experienced a BBA are triaged by a community midwife and, if clinically indicated are advised to be transferred to the relevant maternity unit. Women and babies who are clinically stable are cared for in their home and the majority have chosen not to be admitted to hospital post birth.

[3] Labour ward solutions, Good Practice No.10, RCOG (2010)
[4] Ibid (n5)
[5] Ibid
[6] Ibid
[7] Refers to a baby born before their mother has arrived at her planned place of birth facility or, in the case of a planned home birth, the arrival of the community midwife.

3.2.3 Table 5 shows the number of women who experienced a BBA by booked place of birth.

Table 5 Women who experienced a BBA by planned place of birth and year

Year	EDGH/EMU/CBC	Conquest	CMW ?Home birth	Total
Apr 2012 - Mar 13	9	3	0	11
Apr 2013 - Mar 14	7	13	7	27
Apr 2014- Mar 15	3	8	23	34
Apr 2015- Mar 16	11	14	20	45

Our data was taken from incidents recorded through our reporting software, Datix, and includes women who were booked to deliver in other maternity hospitals but had a BBA. An audit has been commenced on BBAs; this will enable the validation and further analysis of figures.. Our data collected through Datix shows that there has been no detrimental impact upon mothers living in the areas of Eastbourne, Hastings and Rother or High Weald in relation to BBAs following reconfiguration of our maternity services.

3.2.4 MLU closures/diverts was identified by the CQC as an area for improvement. Table 6 shows the number of diverts and closures reported from September 2015 to August 2016 inclusive..

Table 6: the number and impact of diverts per month (including Crowborough Birth Centre [CBC]) from Sept 2015 – March 2016

Month	EMU diverts	CBC diverts	No of women affected	Comment
Sept 15	0	1	0	
Oct 15	0	0	0	
Nov 15	1		0	
Dec 15	0	1	1	Postnatal (PN) woman asked to go to EMU or home - went home
Jan 16	0	1	0	
Feb 16	0	2	2	1of 2, I woman birthed at EMU 2of 2, PN woman transferred home
Mar 16	1	1	0	

The above table shows that between September 2015 and March 2016 we were unable to provide one woman's choice for place of birth due to a divert being in place and two women were transferred to community care earlier than planned.

The diversion of services from the MLU's were due to either staff shortages at the consultant lead unit or due to short term sickness at the MLU with no cover available.

3.2.5 We continue to notify commissioners and Healthwatch of all closures and diverts together with the reasons why they occurred and the impact that may have been felt by the affected women, their babies and their families. Our consultant unit has not closed or diverted women out of East Sussex since we reconfigured our services.

3.2.6 In response to the HOSC recommendation that the maternity pathways for women in the High Weald should be improved to reflect women's cross border birthing choices, an urgent review of the maternity pathway for High Weald was conducted. In November 2015 a joint statement was released from High Weald Lewes Havens (HWLH) CCG, East Sussex Healthcare NHS Trust & Maidstone and Tunbridge Wells NHS Trust (MTW) stating the intention to transfer the management of the maternity services provided within the High Weald area, including Crowborough Birthing Centre (CBC), to Maidstone Tunbridge Wells NHS Trust (MTW). This was confirmed in January 2016.The move responds to feedback received during the *Better Beginnings* consultation and recognises the connections that CBC has with Tunbridge Wells Hospital as the nearest obstetric unit. It will help to provide a more seamless maternity service for women in that area.

3.3 <u>How will we know if we have been successful</u>

3.3.1 We have established a series of key output measures. These numerical measures are tracked on a monthly basis and allow us to see whether the actions we are taking to improve what we do are having the desired effect. The key signs of improvement for clinical performance are:

- Our key outcome indicators will be comparable to or better than the national average
- No BBA will be classified as 'avoidable'

4. Clinical Governance

4.1 <u>Achievements</u>

4.1.1 In collaboration with our commissioners we aim to ensure that our Serious Incident (SI) reporting conforms to the principles of the Serious Incident framework. Our focus is on embedding learning and prevention of harm.

4.1.2 Following the reconfiguration of our maternity services trend analysis of SIs have not identified medical and/or midwifery staffing levels as a theme. There have been no maternal deaths reported by the Trust since 2014.

4.1.3 To ensure that all incidents are appropriately managed it is our policy to log and catalogue all incidents on the trust DATIX reporting system and we continue to undertake Root Cause Analysis (RCA) of all reported S.Is.

4.1.4 A multi-disciplinary review meeting is held daily on our maternity in-patient ward and aims to review all DATIX submitted in the previous 24 – 72 hours. This ensures that if an incident is deemed to be serious it is escalated promptly.

4.1.5 All incidents graded as severity 3 and above are discussed at the trust weekly multi-professional patient safety summit. In addition SIs graded as severity three but not an SI are investigated via RCA.

4.1.6 Table 7 shows the total number Datix reported and SI investigations for calendar years 2012 – 2015 and from January to August 2016

Table 7 total number and triggers for SI investigations 2012-2016

Trigger	Apr 2012-Mar 2013	Apr 2013 – Mar 2014	Apr 2014 – Mar 2015	Apr 2015 – Mar 2016
Transfer to NICU and subsequent neonatal death	1	2	1	1
Neonatal death	6	3	0	0
Intrapartum stillbirth	0	1	3	2
Unexpected stillbirth	12	12	7	2
Intrauterine death	18	11	9	5
Maternal admission to ITU	7	6	1	3
Total	**44**	**35**	**21**	**13**

This table shows the trigger for an SI investigation. We continue to report all unexpected admissions to NICU to commissioners under the Serious Incident reporting framework. The CCG Chief Nurse liaises with the Head of Midwifery to grade these admissions for their level of seriousness.

4.1.7 Learning from incidents and complaints are themed and circulated to all clinical areas as:

'theme of the week' discussed daily at each shift handover.

This is supported by a monthly newsletter on the collated incidents...

A multi-disciplinary seminar titled 'Lessons Learnt' is facilitated by the midwifery and consultant Risk Leads. Previously held quarterly the forum will now be occurring monthly to improve access to all staff

In this way we are continuing to strengthen the services ability to learn, share and own incidents

4.1.8 Our revised system in which the obstetric consultant on call is responsible for contemporaneous assessments of operative deliveries and high risk obstetric and gynaecological cases has led to an increase in the number of consultants directly involved in clinical governance.

4.1.9 All of our maternity guidelines are compliant with National Institute of Clinical Excellence (NICE) guidance and are ratified via our guidelines forum. All guidelines are available on our intranet.

4.1.10 Staff are encouraged to report issues and risks in all areas of the Trust. Wehave appointed a "Speak Up" Guardian to champion everyone's right to voice their concerns and also to allow staff to raise their issues in a safe and non-threatening atmosphere. Regular feedback is now gathered from our staff and feedback given promptly "You Said, We Did".

4.1.11 We have introduced a clinical area schedule for our Non-Executive Directors to undertake quality walks throughout the Trust.

4.2 Monitoring during Labour

4.2.1 The importance of accurate and timely interpretation of cardiotocograph[8] (CTG) traces is nationally recognised. We continue to focus on the importance of CTG interpretation at our multi-disciplinary maternity services incident review meetings and have introduced a policy for the use of CTG interpretation stickers that will ensure a standardised approach to interpretation. An audit of compliance with this policy will be undertaken in our next audit cycle.

4.2.2 The acquisition of the K2 CTG training programme will consolidate formative assessment and enable focused support in developing competence. We have a commitment from a tertiary centre consultant who delivers two workshops a year on CTG interpretation and management. Furthermore all midwives undertake an annual CTG interpretation assessment as part of their supervisory review.

4.3 Complaints

4.3.1 The maternity department received 26 complaints in the financial year 2015/16. The themes that have been identified from the complaints relate to:

- Standards of care
- communication
- attitude
- provision of services
- patient pathway

Issues identified are dealt with through mandatory training, performance management, individual training, newsletter and handover. The complaints are monitored by the trust board through a quarterly and annual report which includes themes and trends of all complaints.

[8] Cardiotocograph – electronic monitoring of both the foetal hard and the contractions of the uterus

4.4 On–going work

4.4.1 E3 supports our maternity data system. There is a rolling programme of refresher training updates for our maternity staff on our electronic data system. During the month of August all of our maternity support workers received refresher training on specified fields of our data system. Our Maternity Dashboard now has a dedicated Knowledge management support for maternity which supports the validation of our data.

4.4.2 During their inspection of our trust the CQC reported that 46% of the trust's junior medical staff had completed information governance training. This has been addressed individually and with promotion of online training

4.4.3 All patient identifiable information and records on our maternity department will be stored and locked in secured trolleys which are on order and awaiting delivery.

4.4.4 During their inspection the CQC identified that some women were being contacted by a midwife after suffering pregnancy loss. Working in collaboration with adjacent trusts and Health Visiting teams we have developed a Standard Operating Procedure to support communication with and care of women who have suffered pregnancy loss. All incidents are now reported on Datix and referred to the relevant organisation.

4.4.5 To deliver both a strong midwifery and obstetric voice we are revising our maternity managerial structure. Following the resignation of our Head of Midwifery (HoM) we have appointed an Interim HoM and will shortly be advertising for a substantive post-holder, whose role will include a greater strategic remit.

4.4.6 In addition we are introducing a second Clinical Service Manager post with the aim of strengthening clinical leadership and the visibility of senior midwives.

4.5 How will we know if we have been successful

4.5.1 Assurance that lessons from SIs has been learnt is provided by thematic analysis of SI's informing our audit cycles.

4.5.2 Our maternity dashboard provides robust and accurate data that informs our quality monitoring.

4.5.3 Clinical audit contributes to and informs our service quality improvements,

4.5.4 All maternity staff know how to raise an incident, know the latest incident trends/themes and feel empowered to take corrective action following an incident, review an incident and that the organisation as a whole learns from incidents.

4.5.5 Members of staff are clear on the overall achievement of the maternity service and their part in it.

4.5.6 Complaint management tracks and responds to complaints in compliance with good practice standards.

4.5.7 Training records show that all of our staff have received information governance training.

4.5.8 All patient identifiable information and records are stored and locked in secured trolleys

4.5.9 All members of staff have clear lines of accountability and clarity over their own and others roles and responsibilities.

4.5.10 All maternity care pathways are supported by strong and effective multidisciplinary working relationships and teams.

4.5.11 Strong clinical governance arrangements are evidenced

5. Workforce

5.1 Achievements

5.1.1 Since the CQC inspection identified the workforce issues within our maternity services we have undertaken much good work to address staff vacancies including the overseas recruitment of qualified staff.

5.1.2 We are committed to providing a strong professional development programme for all of our staff. This includes the introduction of PROMPT[9] and skills and drills training, subspecialty training for our middle grade doctors and eight of our midwives completing the 'Examination of the Newborn' course with plans to support more midwives to do so. The Examination of the Newborn course develops midwives skills to perform a baby's first full physical examination thereby alleviating the necessity for a woman, who has birthed in one of our hospital/MLU settings, to wait for her baby to be examined by a doctor prior to being transferred to community care.

Midwifery staffing

5.1.3 Birthrate Plus (BR+) is a nationally recognised midwifery workforce tool which recommends a midwife to woman ratio of 1:29. However this ratio will change dependent on the skill-mix model utilised by the service. For example BR+ recommends that Agenda for Change band 3 Maternity Support Workers could comprise up to a maximum of 20% of the required midwifery workforce.

5.1.4 We have introduced the roles of preceptorship midwife to support our newly qualified and newly appointed midwives and midwifery practice education facilitator to support our student midwives. These roles have had a positive impact on our midwifery recruitment. For example, all of our final year student midwives have applied and successfully been recruited to ESHT post qualification and will commence employment with us in October. This can be compared with the previous year when no final year midwifery students applied to work with us.

[9] Practical obstetric multi-professional training

Medical staffing

5.1.5 We have recruited two substantive consultants and a locum consultant to the posts which became vacant since reconfiguration. This enables the consultant team to consistently provide 72 hours of consultant presence across the entire 7 day week. This is above the national average for a unit of this size. One of our new consultant's has a special interest in women with perinatal mental health and is leading on this group of women. Further recruitment is planned.

5.1.6 We have a full complement of middle grade doctors in place; however, on occasion locums have been employed. We endeavour to always employ locums who have experience of working at ESHT wherever possible to cover shifts due to illness or maternity leave. The two vacant associate specialist posts are covered by experienced locums in the interim until conversion to substantive posts.

5.1.7 The single siting of obstetric services has allowed senior middle grade doctors to offer extra support at night and weekend for junior registrars which have in turn resulted in attracting trainees to work with us. Since reconfiguration trainee doctors who originally worked in the unit have requested to rotate into ESHT as registrars from the deanery.

5.1.8 Middle grade staff have access to consultant presence in the unit for 72 hours a week[10] . Outside of these hours all consultants are available to attend within 30 minutes. The junior doctors have reported excellent feedback about accessibility and support[11].

5.2 On-going work

5.2.1 Following the changes to our midwifery management structure (see point 4.4.5 above for further information) we will complete our review of the skill-mix, roles, responsibilities and deployment of our maternity staff by December to ensure that we can provide the flexible, personalised maternity care to which we aspire and midwifery staffing establishments are comparable to BR+ recommendations.

5.2.2 We recognise the importance and value of supernumerary co-ordinators and are committed to supporting this requirement. We are currently advertising and recruiting to 3 WTE midwifery posts which will take us to our full funded establishment and enable us to comply with recognised best practice[12] by have a supernumerary labour ward coordinator on every shift. This will enable us to comply with good practice standards such as achieving 1to1 midwifery care for all women in established labour.

5.2.3 Staff sickness and absence rates are monitored and presented at the Women and Children's accountability meeting. Sickness is dealt with in line with the trusts 'Attendance Management Procedure'. A monthly meeting is held with HR and the maternity service manager to ensure this procedure is being followed. Maternity

[10] This is compliant with nationally recognised good practice standards
[11] Trainee Representative reports 2015/16
[12] Working with Birthrate Plus ®, How this midwifery workforce planning tool can give you assurance about quality and safety, Ball J.A and Washbrook M & The Royal College of Midwives

leave equals 11.15 WTE and is presently being covered by bank and agency midwives. In October it will be 13.33 WTE but month on month following this, the WTE on maternity leave falls.

5.2.4 To ensure the best utilisation and deployment of staff we review midwifery staffing, clinical activity and acuity on a daily basis. To ensure the safety of the service during times of high activity or unplanned staff sickness on our Conquest site it is sometimes necessary to redeploy our community midwifery staff or midwives from our Eastbourne Midwifery Led Unit (EMLU) to our Conquest site to meet demand. This may result in a woman being diverted to another facility and/or the closure of EMLU. Please see section 3.2.4 above for further information

5.2.5 During times of unscheduled sickness agency midwives are utilised at the Conquest maternity unit. Table 8 shows agency midwives usage in hours from August 2015 to July 2016.

MTH	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**April**	**May**	**June**	**July**
Ag in hrs	621	782	736	517.	379	471.5	816.5	851	333.5	529	632.5	609.5

There is no upward trend on the use of Agency Midwives. The agency midwives that work at the Conquest are regular agency midwives and have had an induction to the maternity unit. From October 2016 we will be recruited to full establishment.

5.2.6 Plans are being put in place to change the on-call rota for community midwives who support home births. This will provide greater availability of midwives to support home births, giving women more choice about where they have their baby. Our planned changes will reduce the on-call hours that community midwives work, which was an area of concern raised by the CQC.

5.3 <u>How will we know if we have been successful</u>

5.3.1 Women and their babies receive high quality, safe and appropriate care avoiding unnecessary interventions.

5.3.2 Our workforce is affordable and sustainable

5.3.3 Our staff survey shows us that staff satisfaction has increased, leading to better recruitment and retention

6. Stakeholder Engagement

6.1 <u>Achievements</u>

6.1.1 At ESHT we aim to become more inclusive and collaborative when improving and developing our services. To support this ambition we have developed a new communications and engagement strategy that will improve and expand our relationships and our engagement with external stakeholders.

6.1.2 To deliver our stated commitment we have initiated a Stakeholder Engagement Improvement Project aimed at strengthening patient and public engagement and promoting a culture of continuing quality service improvement.

6.1.3 We have worked collaboratively on a series of projects with Healthwatch East Sussex (HWES) including a review of our maternity services provision.

6.1.4 The recommendations from the resulting maternity review report[13] and the actions we have taken to date are shown in table 9

Table 9 HWES maternity review (2016) recommendations and trust actions

Recommendation	Action
Ensure there is a clear protocol in place, for the safety of the child and mothers during travel arrangements between the maternity units. This should be available and communicated to parents, so they can understand where accountability and responsibility lies whilst travelling	We have developed a guideline for 'Birth within the home environment or midwife led Unit' for staff. In addition an information leaflet for woman and their families is now available and discussed with all women as part of their antenatal risk assessment.
Provide clear guidelines for fathers and partners, developing an information leaflet to include information on supporting the mother: during hospital appointments, hospital stays, following a caesarean section; and visiting arrangements relevant to each site including out of hours arrangements.	Leaflets and information are now available on ESHT maternity website
Build into birth and support plans, information about home circumstances, including any older children to increase the awareness of staff of other pressures on mothers/parents.	This is discussed with all women at their booking appointment. However, we appreciate a woman's situations may change therefore we maintain an open dialogue to update circumstances.
Review access arrangements to wards at night, and how this information is communicated to parents	Women are informed of access arrangements by their midwife as part of their antenatal care.
Have a dedicated member of staff available on each shift to support women with breast feeding, and ensure that women know who the member of staff is.	We now have an infant feeding specialist midwife whose remit includes the training of all maternity staff thereby ensuring that all staff on duty are able to offer good practice breastfeeding support to women.
Explore the possibilities of introducing a parking ceiling tariff for fathers and partners who are supporting the mother, particularly during protracted labour	Although we are unable to offer concessions to all service users concessions are discussed with woman and their partners on an individual bases.
Review the system in place for labour induction, with the objective of minimising long delays	This system has been reviewed by senior medical staff and midwives and an escalation policy developed
Ensure information boards are kept updated and that all information displayed is consistent and current;	Our maternity matrons now lead on ensuring all boards are kept updated.
Agree the mechanism by which East Sussex Healthcare NHS Trust will respond to the action and learning plan developed by the working group	Via Director of Nursing

[13] Special measures, to special moments, Healthwatch East Sussex (April 2016)

6.1.5 To support women whose first language is not English, we have identified the top 3 languages spoken by our maternity service users and, in collaboration with our newly awarded translation service contractors, have worked to ensure that the standard maternity information leaflets are available in the identified languages.

6.1.6 We offer women a choice on where and how they access their care. At our EMU, women can attend for care at a timed appointment and, to provide more localised care, community midwifery teams provide services from Shinewater Children's Centre, Hampden Park Children's Centre and locations within Eastbourne and surrounding areas.

6.1.7 As part of our stakeholder engagement strategy our maternity service staff actively promote the Friends and Family Test (FFT) facility to all women accessing maternity care at ESHT. This feedback is regularly reviewed at our monthly Clinical Quality Review Group. Table 10 shows the percentage of returns received for selected years.

Table 10: FFT returns for 2013-14, 2014-15 and 2015-16

Touchpoint	Aug 2013 – Aug 2014	Aug 2014-Aug 2015	2015-16
Antenatal	86.37%	88.5%	89.6%
Birth	85.89%	85.89%	92.14%
Postnatal (community)	93.12%	93.49%	95%

The above table shows a year on year increase in the number of FFT responses in all three categories and our latest data shows that more than 95% of respondents would recommend having their baby with us.

6.1.8 We are particularly proud of the feedback we received following Healthwatch East Sussex call for evidence from our maternity services users. Most of the 50 parents and partners spoken to rated our services as good or excellent[14] whilst one woman rated our Eastbourne Midwifery Unit as '*gold standard'.*[15]

6.2 <u>On-going work</u>

6.2.1 Women and their families who have used our maternity services, together with staff, were asked for their views to help shape improvements in our maternity services. Some of the resulting recommendations have addressed concerns raised by the CQC following their inspection in 2015. This work has also informed the on-going development of our new Maternity Strategy which is being developed with multiagency input from providers, commissioners, public health and our Maternity Service Liaison Committee (MSLC). This includes the development of a new maternity service specification.

6.2.2 An enthusiastic group of staff, local women and MSLC members are building upon the success of the birthing centre and promoting services that are available at EMU,

[14] Special measures, to special moments, Healthwatch East Sussex (Aril 2016)
[15] Ibid

these include: neonatal hearing screening, breast feeding drop in support, BCG clinics, tongue tie clinics and home birth workshops.

6.2.3 To strengthen the information and preparation available to women and their families accessing maternity care we have developed a virtual tour of our maternity facilities which will shortly be available on our website. In addition we are currently working with our Clinical Commissioning Group to review how the Parent Education needs of our maternity service users can be met.

6.3 How will we know if we have been successful

6.3.1 We have a signed-off Maternity Strategy and Maternity Service Specification (developed through staff and wider stakeholder engagement, including maternity service users) that clearly defines how our vision for a high quality, safe and clinically effective service that provides a positive experience for all users of our maternity services will be turned into reality.

6.3.2 An action plan, monitored by our Trust board, sets out the developments and changes required, by whom and by when to realise our vision.

6.3.3 Stakeholder engagement (including a fully supported MSLC) are represented at all levels within our maternity service provision

7. Environment

7.1 Achievements

Much work has been undertaken to address the general environment in which our maternity services are provided with some works on-going as they require capital investment. In particular we have:

- Refurbished the reception area on the labour ward at Conquest Hospital

- Improved the cleanliness and tidiness or our maternity facilities by recruiting 4 ward orderlies who will work with and support our maternity staff to maintain the high standards to which we aspire.

- We have also recruited staff to be able to conduct the number of necessary audits required to meet the National Standards of Cleanliness, both in terms of the frequency with which areas were cleaned and the frequency with which cleanliness is checked. Cleanliness issues are reported through a new computer system and issues reported to a new governance group where actions to address issues are documented and followed up.

- We have introduced a new food menu ‘Steam Plicity’. Women choose from a menu and the food is cooked on the ward and served directly to them. Since the introduction of this system the feedback through the FFT has been positive.

  The doors onto the lake side of our Conquest site were opened by staff during hot weather to provide ventilation. The CQC identified this as a security risk.

The doors have now been redesigned to allow ventilation whilst not permitting unauthorised access.

- All fridges used for storage of medicines within our trust are fitted with a lock and the temperature of the fridge is checked and recorded daily on a check list.

7.2 On-going work

7.2.1 Work is on-going to secure the capital investment required to renovate our Eastbourne Midwifery Led Unit.

7.3 How will we know if we have been successful

7.3.1 We continue to receive positive feedback from our maternity service users regarding the quality of food and the cleanliness of our maternity services environment.

7.3.2 Assurance gained from environment audits.

8. Conclusion

8.1 We are proud of the work our marvellous teams have achieved to date and will continue to build on these achievements. However we are not complacent. We recognise that there is work still to be done. In particular:

- Normalising birth on our Conquest site
- A continued review and monitoring of our governance system
- Closing the loop when learning lessons from SIs

8.2 We are confident that the changes and actions articulated in this paper will enable us to deliver the maternity services to which we aspire that meet the needs of our maternity service users of the future.

‘

Quotes from women’ (2016)

‘I had an excellent experience having my son at Eastbourne. The midwives were fantastic. I was the only one on the ward and I felt completely safe in their care. Would use Eastbourne again and not enough is said about the successful births there, you just hear the negative.’

‘The service was second to none, I was treated with the upmost care and dignity and my wishes were respected at all times.’

‘You know that they are listening to you even without you saying anything. ‘

‘All the questions I had, however silly, were always answered and they made sure I understood fully. It was not just my baby they asked questions about, but me and family/home life to.’