Portsmouth Hospitals NHS
NHS Trust

Maternity Services

'Nurturing Maternity Service Development'

September 2011

Name of Responsible NHS Body: Portsmouth Hospitals NHS Trust

Brief description of the proposal.

The maternity service has launched a 2 year development programme. This is in line with the South Central Strategic Health Authority Maternity Programme and is being conducted in agreement with NHS commissioners, clinicians, stakeholders and users. The following priorities have been agreed :

- Promoting family centred maternity care.
- Providing one to one midwifery care in labour to maintain all options for place of birth (home, stand alone maternity centre's, integrated birth centre and consultant led labour ward.
- Develop and support efficient and effective obstetric and midwifery led antenatal services in partnership with GPs, health visitors and working through Children's Centres
- Provide additional care for vulnerable women with complex social, medical and obstetric needs to improve their outcomes.

These priorities will be achieved by ensuring care is evidenced based, flexible, affordable and evaluated.

Description of population affected:

Predominantly women residing in Portsmouth and East Hampshire who book with Portsmouth Hospital Maternity services.

The launch of the programme and the initial paper was presented to the joint Hampshire and Portsmouth Health Overview and Scrutiny Committee meeting on 24th March 2011.

Stakeholders supporting the proposal for change: Portsmouth and Hampshire NHS Commissioners; Solent Health Care; Maternity Services Liaison Committee; National Childbirth Trust; Bournemouth University; Portsmouth Children's Trust; Local authority Children's Centres; Friends of the Grange; Blake support group; Portsmouth Hospitals NHS Trust board and clinical staff; Royal College of Midwives.

Introduction

Portsmouth Hospitals NHS Trust maternity service is a large complex service caring for more than 6000 mothers and babies each year. The acute service is based at the Queen Alexandra Hospital, which has an integrated midwifery led unit, in-patient antenatal, postnatal and labour care, obstetric scanning, fetal medicine and consultant obstetric care with access to a level 3 Neonatal Unit.

The community services provide midwifery and obstetric services from community units, children's centres and GP practices. There are also midwifery led birth centres at St Mary's Hospital, Blake and The Grange and community antenatal and postnatal care, parent education and a home birth service.

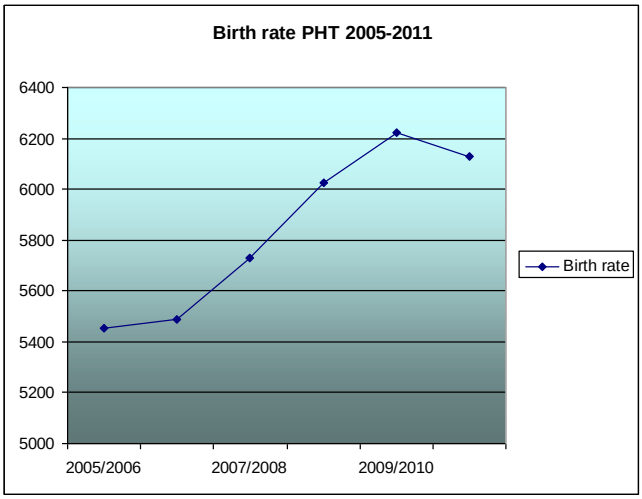
There are many examples of good practice in the service and notable achievements, such as the normal birth rate (unassisted vaginal birth, i.e. without instrument or surgery), which is higher than many of the Hospital Trusts across the South Central Strategic Health Authority. However, it has been expressed by commissioners, Portsmouth Hospital Trust staff, the Strategic Health Authority and, most recently, a peer review of the service that change is required. This will focus on improving clinical outcomes, particularly the caesarean section rate; improving access to antenatal and postnatal care, maintaining choice of place of birth (and maintaining the standalone birth centres) and ensure evidenced based, cost effective, seamless maternity pathways.

The Sustainability Team consisting of Hampshire and Portsmouth commissioners, PHT maternity services and the Maternity Services Liaison Committee have agreed a direction of travel for maternity services. This steering group is chaired by Linda Collie a Portsmouth GP. The priorities and work streams within this 2-year development programme are at Appendix 1.

Birth rate and neonatal outcome

The Portsmouth maternity service has seen a considerable rise in activity over the last 5 years. It is anticipated that whilst there are fluctuations in birth rate throughout the calendar year, the overall rate will stabilise over the next few years.

Fig 1

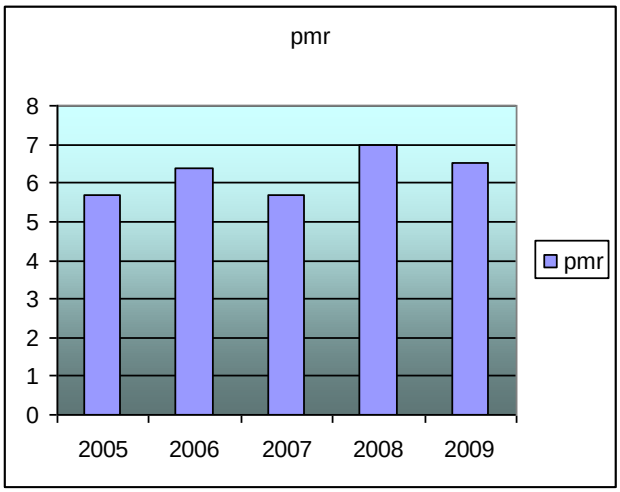


Total births for Portsmouth Hospitals Trust including home and birth centres

The ultimate measure of service safety is the Perinatal Mortality Rate (PMR). The national average is *6.8* perinatal deaths per 1000 births (stillbirths and neonatal deaths), South Central average is *6.0/1000* and PHT is *6.5/1000 from the latest report in 2009.*

The trend for PHT has been fairly static for the last 5 years with a small decrease in 2009 from 2008.

Fig 2



Perinatal Mortality rate for Portsmouth Hospitals Trust 2005-2009 (CEMACE 2009)

A compelling case for change

A review of the maternity service by the trust and commissioners has highlighted key areas for further development.

- Lack of user and stakeholder confidence in the longevity of the stand alone birth centres
- Lack of flexibility with the midwifery workforce to ensure one to one care in labour and support for ill mothers and babies, in all settings
- Inconsistent postnatal support in the community, particularly for vulnerable families.
- A higher than average caesarean section rate
- Women in normal labour cared for on the high risk labour ward, preventing access for ill women and those whose babies need intensive neonatal care.
- Services provided by PHT and not funded by commissioners (eg aquanatal, postnatal counselling, in-patient postnatal support for well mothers and babies)
- An increasing number of mothers with complex pregnancies, due to increasing age, obesity, medical advances, requiring intense multidisciplinary care.
- A growing number of socially vulnerable mothers and families, who need focused support to achieve positive clinical outcomes and support for positive parenting.
- Many other maternity services (Southampton and Oxford locally) have implemented a similar model of care with demonstrable improvement in outcomes.

Proposed change to service provision.

The main changes are summarised as follows:

- The birth centres will be further developed into local maternity centres (St Mary's, Blake and Grange), with an increase in midwifery led antenatal care provision, education, information and delivery of enhanced services to vulnerable families (eg teenage groups, family nurse partnership). Focused postnatal support in clinics, breastfeeding and parenting advice.
- Births at the centres and at home will be further encouraged and provided 24 hours a day for women of low risk of complication.
- Women and babies who are well after birth will be encouraged to return home as soon as possible to their families (Keeping mum, dad, baby and extended family together) leading to a reduction in postnatal stay for well women and freeing up midwives to provide care for women in labour.
- Increased postnatal community support from an increased establishment of senior maternity support workers, trained to the agreed SHA competencies, supporting breastfeeding and early parenting, allowing more focused midwifery support for ill and vulnerable mothers
- Increased flexibility for the midwifery workforce to provide one to one care in labour in all settings
- An increase in community midwifery care delivered from Children's centres' as per the 'Pre Birth to Five Strategy'
- Development of stronger partnerships with Health Visitors, G.P and midwives, with named teams. Clear focus of joint care planning for vulnerable families.
- Consultant led care for women with or at risk of complications to be mainly delivered at QA (peripheral obstetric clinics are being reviewed, some will be maintained)
- Unfunded services will be passed to 3rd party providers (eg aquanatal to local swimming pools)
- Internal strategies will be further developed to promote normal birth (eg encouraging vaginal birth after caesarean section and all women choosing QA who are low risk of complication start their labour journey on the Mary Rose integrated birth centre)

Improving outcomes.

Workstream 1: Service model and pathways (Chaired by Gill Walton, Head of Midwifery- community midwives, human resources, Supervisor of Midwives, Bournemouth University, maternity support workers)

- It is intended that following this change more Portsmouth and Hampshire mothers will have a choice of place of birth and will receive one to one care by a midwife.
- Fewer women will be denied their choice of place of birth.
- The labour ward capacity will be available for mothers who need that level of care, therefore reducing the number of mothers denied transfer from other units and the potential of improving out comes particularly for premature and sick babies
- Continued reduction in caesarean section rates and associated morbidity and increased vaginal birth rates
- Improved breastfeeding rates, current target is 80% of mothers initiating breastfeeding, the service is currently at an average of 78%

Workstream 2: Normalising birth and reducing caesarean section (Chaired by Saumitra Sengupta- Consultant Obstetrician, midwives, obstetricians, commissioners from Portsmouth and Hampshire, Bournemouth University, anaesthetist)

- Reduction in labour and postnatal complications
- Increased satisfaction
- More empowered women
- Enhanced postnatal recovery

Workstream 3: Improving care in obstetric theatres (Chaired by Marie Flynn, Head of Nursing for theatres, staff from theatres and maternity, infection control, practice education, anaesthetics,)

- Increased efficiency
- Lower wound infection rates
- More responsive in an emergency

Workstream 4: Antenatal care (Chaired by David Davies, Chief of service, consultant obstetrician, midwives and obstetricians, ultrasonographer)

- Appropriate health profession planning care
- Improved continuity
- A reduction in unscheduled antenatal care
- All clinicians reaching consensus on antenatal pathways so that consistency is assured

Workstream 5 Developing Maternity Support Worker's and clerical teams. (Chaired by Jane Parker-Wisdom Midwifery Community manager, midwives, practice educators and Maternity Support Workers)

- Improved support for postnatal mothers in the community
- Increased breastfeeding continuation
- Increased midwifery support to vulnerable mothers
- Efficient use of resource

Workstream 6: Evidenced, based care, consensus and clinical leadership (Chaired by Sharon Hackett-Clinical Governance lead, obstetricians, midwives, Neonatal unit, Supervisors of midwives)

- Responsive service,
- Care based on evidence
- Consistency of support and advice

Conclusion

This change is well supported by service users, clinical staff and stakeholders. It is a cost effective sustainable change and seeks to reduce risk to mothers in labour, improve choice of place of birth and improve care to ill and vulnerable mothers.

Creating confidence in the service is key and developing the services within the birth centres is an important part of that plan. The main change to the service model is proposed for January 2012 and all changes will be evaluated.

Gill Walton
Head of Midwifery
Portsmouth Hospitals NHS Trust

References

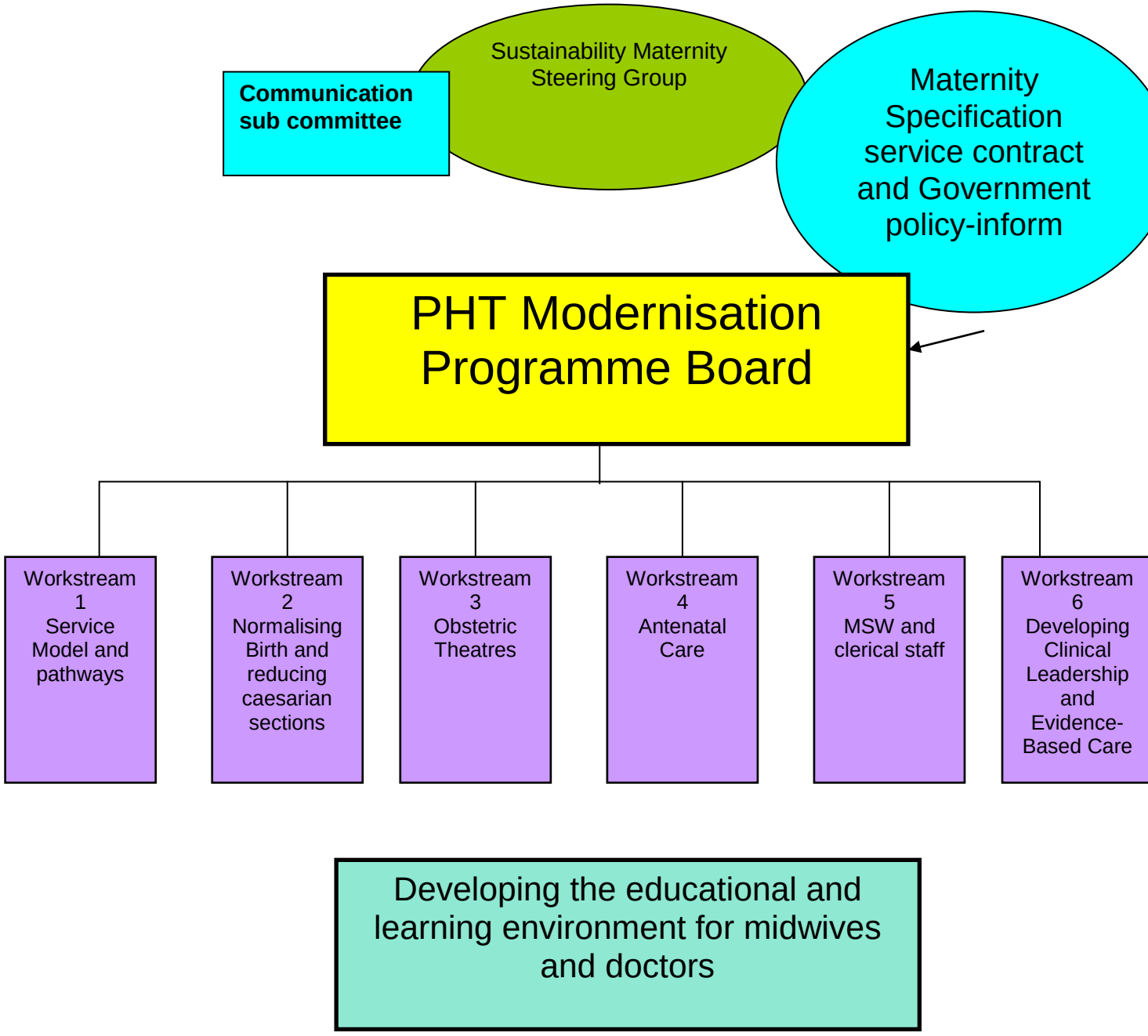
CMACE (2009) Perinatal Mortality Final Feedback Report, Portsmouth Hospitals NHS Trust

Appendix 1

Modernisation Programme Framework

Several workstreams have been indentified, which would come under the modernisation agenda, headed by a representative steering group.

Nurturing Maternity Service Development-Family Centered Care



1 Sustainability Maternity Steering Group and Stakeholders

This group has been established by the Sustainability Group in partnership with Portsmouth and Hampshire Commissioners and PHT maternity services. This group will respond to current maternity policy, NICE guidance, and targets to set the agenda for maternity service development, whilst ensuring outcomes are maintained and improved, and the service becomes cost effective.

2 Communication Subcommittee

Maternity services are the shop window of NHS services as most women who use the service have a positive outcome and therefore the NHS has an opportunity to influence the perception of local families about hospital and community services. Most people know someone who has had a baby and, for many families, it is the first time they have accessed NHS care. Investing in a comprehensive communication strategy for this programme is essential to maintain confidence in the service, which is being developed. A key to this will be the involvement of user and user groups at all levels of the programme, including small focus groups for some of the workstreams.

3 PHT Modernisation Programme Board

The main purpose of this group is to provide direction and governance to the workstreams. The Board will hold the workstream leads to account (through the project manager) for key deliverables. The Board will link to the Trust Governance Framework in order to ensure transparency and clear identification of risks and taking steps to mitigate these risks.

4 Workstreams

(i) **Service model and maternity pathways** - This will include a review of midwifery caseloads, staffing of the birth centres, minimum and optimum staffing in the acute unit, skill mix, the provision of community services and the development of a clear escalation for midwives to care for women in labour.

(ii) **Normalising birth and reducing caesarian sections** - there are many elements to this workstream. Having a one to one care in labour priority is fundamental to achieving normal birth and ensuring opportunities for low risk women to birth away from an acute labour ward, preferably out of hospital. This will also include senior obstetric support on the labour ward, VBAC pathways, induction of labour and the environment of birth.

(iii) **Obstetric theatres** - developing the appropriate staffing model, efficient elective pathways and meeting obstetric theatre guidelines.

(iv) **Antenatal Care** - This will include care in the right place, ie Consultant led care in the acute unit and community antenatal care through children's

centres and the birth centres. A key part of this workstream is ensuring clear antenatal pathways, enhancing the use of specialist midwives and developing midwifery led care for moderate risk women. This workstream will also include access and unscheduled antenatal care.

(v) **Maternity Support workers and clerical staff** - Developing supporting roles in the priority of all the workstreams. The focus will be on postnatal care in the community in order to release midwives to provide care in labour and improve antenatal continuity.

(vi) **Developing clinical leadership and evidenced based care** - In order for women to have access to a dynamic and responsive service there requires a focus on developing clinical leadership in both obstetrics and midwifery. The underpinning evidence for all pathways should clear and agreed by the multiprofessional team.

5 Underpinning Themes

(i) **Family Centered care: involving fathers** - This is an emerging priority for maternity service, with clear evidence that involving fathers enhances their experience and their approach to parenthood.

(ii) **Developing the educational and learning environment for midwives and doctors** - There are many opportunities for learning which can be enhanced. Developing the ability for midwives and obstetricians to learn together is key. The service is one of the largest in the South of England and provides an ideal opportunity for our own staff and the sharing of our experience with others.

(iii) **Developing contemporary midwifery** – As advocates for women, whichever pathway they are on is the key role of the midwife. Midwifery is an autonomous profession, more closely aligned to medicine than nursing. Understanding the uniqueness of midwifery in ensuring clear and empowered decisions with women and families, whilst developing a clear professional image, is the direction of travel.