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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL
'TO FOLLOW' REPORT - MATERNITY SERVICES

DATE: **WEDNESDAY 14 APRIL, 2010**
TIME: **10.00 A.M.**
PLACE: **COUNCIL HOUSE (NEXT TO THE CIVIC CENTRE), PLYMOUTH, PL1 2AA**

Committee Members–
Councillor Mrs. Watkins, Chair.
Councillor Mrs. Aspinall, Vice-Chair.
Councillors Berrow, Browne, Delbridge, Gordon, Kerswell, Mrs. Nicholson and Stark.

Co-opted Representatives-
Chris Boote, Local Involvement Network (LINk).
Margaret Schwarz, Plymouth Hospitals NHS Trust.

PLEASE FIND ATTACHED A COPY OF A REPORT FOR CONSIDERATION UNDER AGENDA ITEM NO. 4.

BARRY KEEL
CHIEF EXECUTIVE

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

4. MATERNITY SERVICES (Pages 1 - 14)

To hear from the Plymouth Hospitals NHS Trust with regard to provision of its maternity services.

Agenda Item 4

Plymouth Hospitals NHS
NHS Trust

Reproductive health, Women's and Neonatal Services Directorate

Report to Overview and Scrutiny Panel – Plymouth City Council

Nicky Phillips
Acting Head of Midwifery
March 2010

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1. Introduction

At present, the maternity services provided by Plymouth Hospitals NHS Trust at Derriford Hospital are designed to provide care for all pregnant women in Plymouth. There are low- and high-risk care pathways designed to meet the varying needs of the population. Continual and expert risk assessment of women's needs throughout their maternity care prompts referral between the pathways.

Choice in the type of care and where it could be provided was a key initiative set out in Maternity Matters (Department of Health (DH), 2007) with a target date for implementation by 2009. The focus of choice surrounded provision of antenatal and intrapartum care, in particular for low-risk women. Strategic planning and service development has given rise to choice for provision of antenatal in a variety of community settings together with hospital-based care. Choice for intrapartum care has focused upon provision of a midwifery-led unit together with an increase in homebirth rates.

A paper has been submitted to the Trust Board outlining the case for developing the maternity services by establishing a midwifery led unit for the women of Plymouth and surrounding areas, in line with the overarching Maternity Strategy. This is part of the "Maternity and Newborn" strategic care programme identified by Plymouth Hospitals NHS Trust and outlined in the Trusts integrated business plans for 2010.

Within the current service, women are able to choose between birth in a consultant led unit (97.5% of women living in Plymouth did so in 2007/8), and birth at home (2.5% in 2007/8). The provision of midwifery led units is essential for the proposed improvements to maternity services that will ensure quality of care and choice for women, in line with national and local requirements, at a level appropriate for their clinical need. High risk and low risk care pathways have been developed, and the midwifery led units are key to implementing the low risk pathway. Evidence suggests that women with uncomplicated pregnancies have improved outcomes at midwifery led units.

This service development is a national requirement, outlined in the most recent Department of Health and local commissioning guidance:

- Maternity Matters (DH 2007) identifies the importance of choice of place of birth, including birth in a local midwifery led unit or birth centre, supported by a midwife. This choice should have been available to all women by the end of March 2009.
- The Strategic Health Authority, NHS South West (2008), has set a more specific target: 30% of all births should take place in midwifery led units by the end of March 2011.
- Included as a local priority within the service specification for hospital and community maternity services: "Midwifery led unit – interim June 2009, completion 2011".

However, there is also a need to demonstrate highly developed clinical practice across the full scope of midwifery practice. Women with high risk factors and potential complications should be offered choice of care provision. Antenatal care and labour supported by maternity teams is consistent with such guarantees (Maternity Matters, 2007). It provides an improved model of integrated services available to the woman.

Maternity teams concerned with high risk antenatal and labour ward care with dynamic, clear leadership are critical factors in providing safety (Healthcare Commission, 2008). A core of midwives with additional skills concerned with the management of complex obstetric problems is recommended as part of a high-risk team (Safer Childbirth 2007).

Currently, there is provision for management of women with high risk clinical conditions within the high dependency unit (HDU) on the labour ward where there is a core of obstetricians and midwives with additional skills in HDU care. However, for antenatal patients that fall outside the parameters of high risk care but cannot be considered to be low risk are cared for in the general ward environment, which has minimal provision of equipment or staff for expert care.

In terms of safety for pregnant women, extension of labour ward services to provide care for high risk antenatal women who do not require HDU care must be considered. The benefits include:

- Multidisciplinary team with additional skills located on labour ward - improved access to care
- Minimal disruption of care as patient located within environment with immediate access to staff, facilities and equipment in case of emergency
- Improvement in patient experience, satisfaction and safety
- Reduction of complaints, incidents and litigation.

2. Norfolk Ward Update

Who were the auditors who recommended closure of the 24 bedded wards?
Norfolk Ward has not closed. However, the use of the ward has changed. The 24 beds on Norfolk Ward were historically used for antenatal and postnatal women. The ward is now used mainly for antenatal women who have some complications with their pregnancy.

Evidence from data performance showed that the Maternity unit had a 64% bed occupancy rate from Sept 08 to August 09 – compared to an acceptable bed occupancy rate of 85% (any more than 85% can show an increase in hospital acquired infection). This initial data gave the Maternity Services the scope to look at how we can utilise the Maternity footprint is a way that is more relevant to the needs of the women.

Previously there were two rosters – one for Norfolk ward and one for Argyll ward. There is now one roster and all staff from Argyll & Norfolk wards now report for duty on Argyll ward and are relocated to the busy areas in the department – usually Triage and High Risk Antenatal ward (previously called Norfolk).

3. Introduction of Triage

Telephone triage can benefit both women and the midwifery services by avoiding unnecessary attendance to hospital.

The role of the triage midwife is demanding requiring a wide range of midwifery skills and ability to prioritize a heavy workload in a busy Maternity Unit. It is well recognised that there is a national shortage of Midwives and although Derriford hospital is currently working to an establishment of 1:32 (Midwife to delivery) it is important to recognise that services need to be run efficiently to provide the best experiences for women and their families. Triage has a huge part to play in the effective and efficient management of the women who present to Derriford for advice and help.

All self referral calls to wards and other departments will be transferred to the Triage phone as will all primary care calls from GP's/Devon Doctors etc. There will be a very clear operating policy for Triage and there will be some women who require direct admission to Central Delivery Suite. This is clearly documented in the Standard Operating Policy for Triage. During the pilot the message handling number for Community Midwives will remain but the option to transfer calls to the Triage service will be available.

It is expected that the reduction of inpatients will ultimately reduce the amount of beds needed within the Maternity Unit. Reduction in the number of antenatal admissions and increasing the number of women discharged home as opposed to admission to the wards.

Women can be admitted for assessment of labour and then discharged if appropriate thereby reducing the number of non-labouring women on the labour ward.

Maternity triage services are a relatively new addition to maternity services but the concept is becoming a popular practice. It is recognized that the majority of pregnancy complaints can be dealt with in other settings other than the labour ward and that the majority of complaints are not related to labour.

The Triage midwife is allocated to the service on a shift basis and does not go to the Central Delivery Suite.

4. Transitional Care Ward (TCW) & Neonatal Intensive Care Unit (NICU)

The Transitional Care Ward has traditionally had four overflow beds to cater for well babies in times of peak capacity. However with the reconfiguration of

neonatal services this area has now been turned into a nursery. However there are still occasions of peak capacity where if beds on TCW are available and are not needed for any transitional care or neonatal babies and their mums they can and should be used for normal care women who require a hospital stay.

When the Neonatal unit is full there are clear guidelines around how to escalate this to the Network and how to locate Neonatal cots across the South West and beyond.

The purpose of this document is to provide a basis on which safe and appropriate in utero-transfers (IUT) can take place with an overall objective to provide a service that facilitates the best possible outcome for babies and their families.

Derriford Hospital is classified as a level 3 unit which provides care to babies of a low gestational age (from 23 weeks). This means that many IUT are accepted into Derriford Hospital's maternity unit from other units, particularly within the South West Peninsular such as Torbay, Exeter, Barnstaple and Treliske.

The designation of neonatal care is clearly defined in the British Association for Perinatal Medicine as follows:

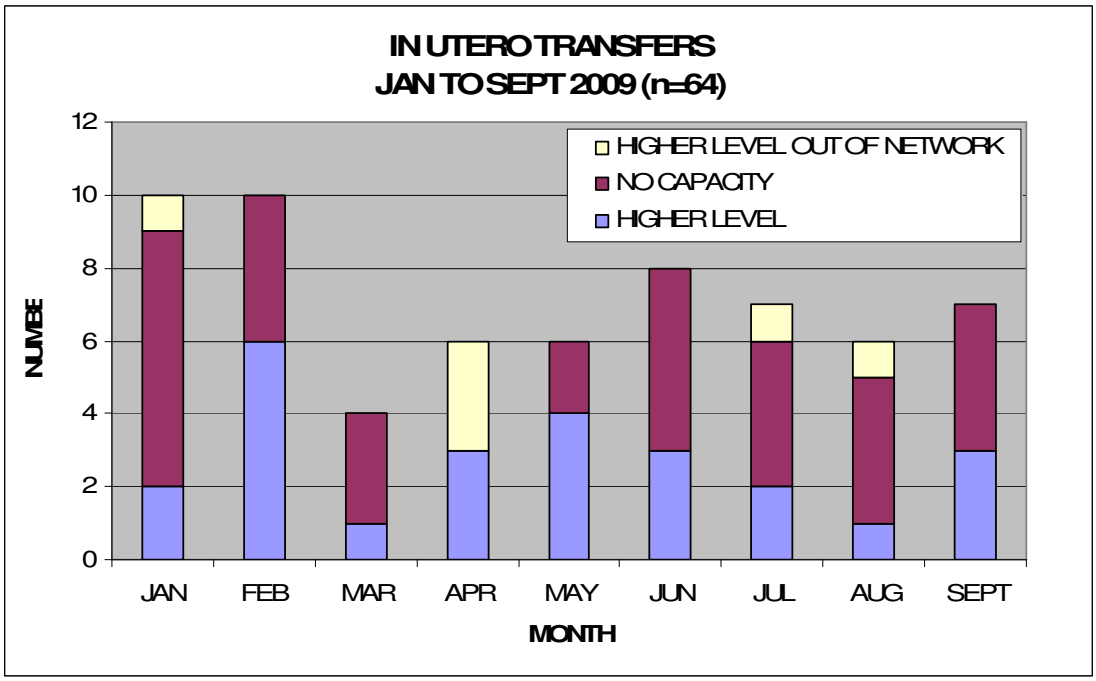
Level 1: Units provide Special Care but do not aim to provide any continuing High dependency or Intensive Care. This term includes units with or without resident medical staff
Level 2: Units provide High Dependency Care and some short term Intensive Care as agreed within the Network
Level 3: Provides the whole range of medical neonatal care but not necessarily all specialist services such as neonatal surgery.

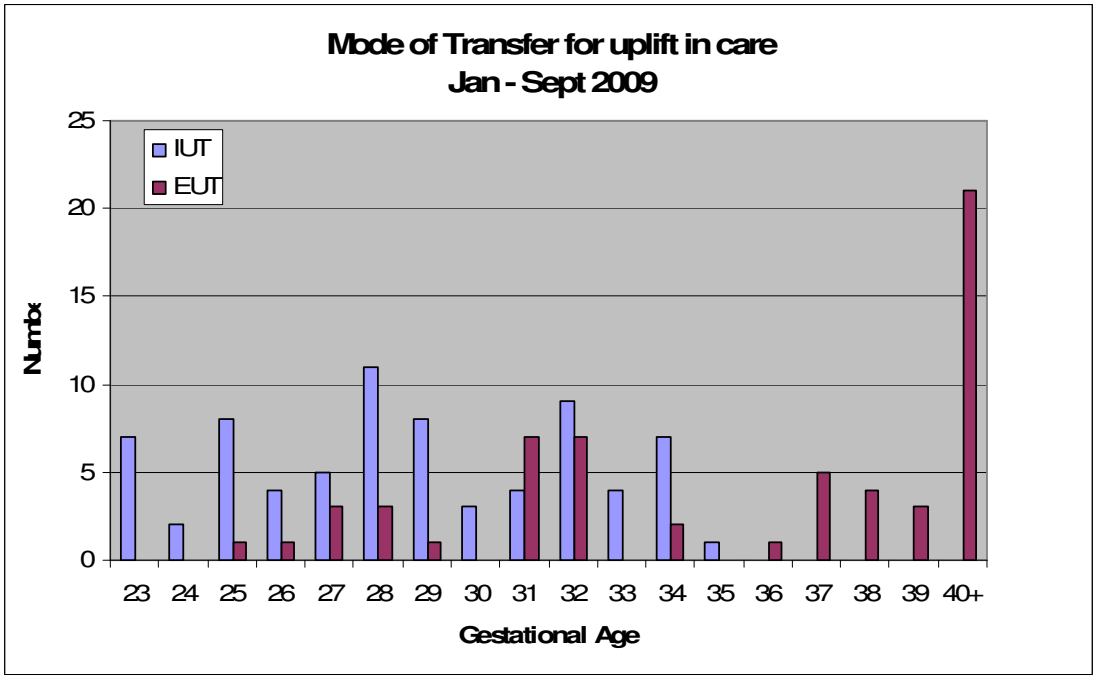
To reduce the number of IUT, which are a source of significant anxiety for parents, having both a financial and psychological impact on the family, the decision and rationale for transfer has to be clear and made at Consultant Obstetrician level. Fewer than 50% of women presenting with suspected preterm labour will deliver during the current episode. In depth clinical assessment is important in determining the risk of preterm labour and should include diagnostic tests such as fetal fibronectin which is a proven efficient short term marker of preterm delivery, see Preterm Labour Guidelines.
The reasons for needing to transfer a woman out to another hospital are many and include:

- Need for enhanced care for mother, neonate.
- NICU closed
- Neonatal request (Staffing/workload)
- Delivery suite capacity

The decision as to whether it is safe to transfer will be made by the Obstetrician and if they are of the opinion that the IUT is inappropriate for reasons of maternal and fetal safety, then the transfer should not take place.

Data is kept on all transfers within the Network including the reason for transfer, the reason for refusal the method of transfer and other clinical data.

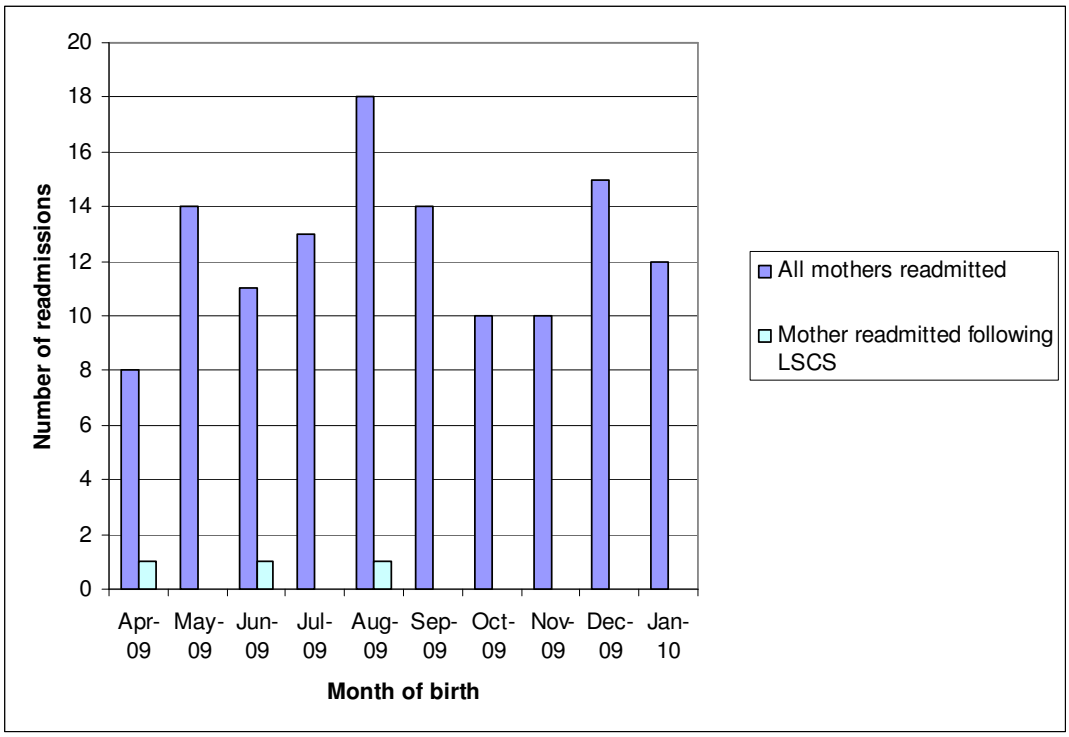




5. Readmission Rates

Tables 1 and 2 below show readmissions to the maternity department within 28 days of birth.

Table 1: The number of mothers readmitted to the maternity department within 28 days of their delivery date, from April 2009 to January 2010



The month of birth is given along the x axis; therefore January 2010 data includes all mothers or babies born during January, and readmitted up to 28 days following the birth (i.e. up to 28th February). This is therefore the most up to date data available.

Both tables 1 and 2 below show very small numbers of readmissions to Maternity within 28 days.

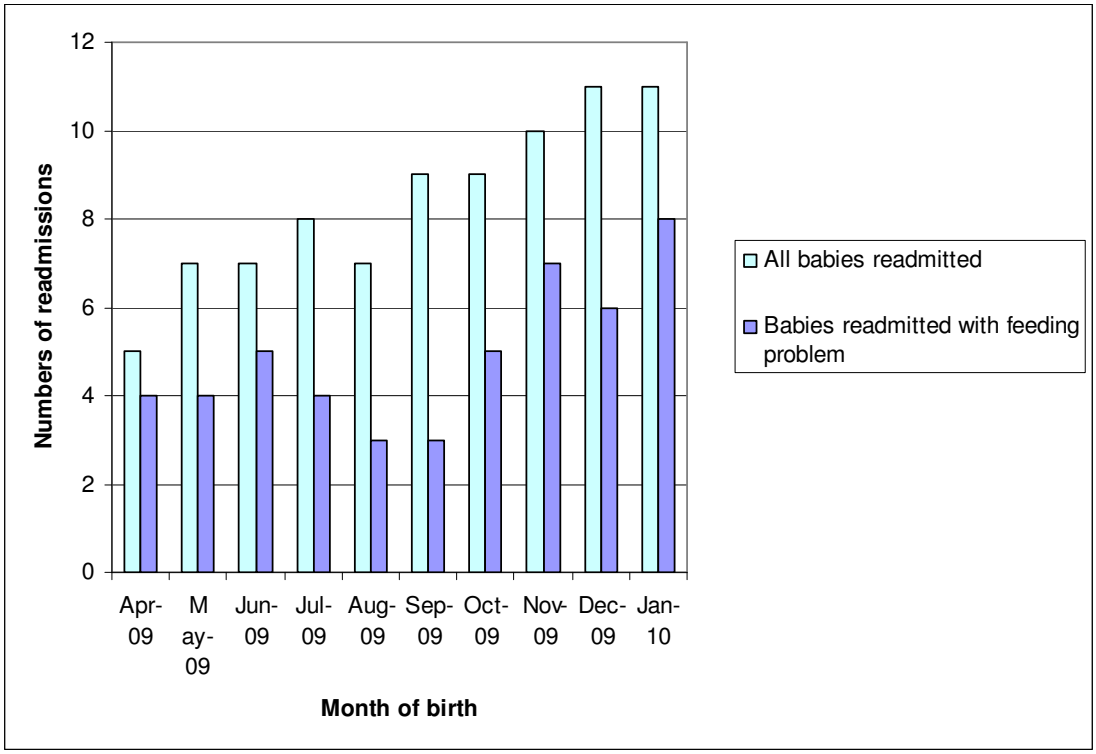


Table 2: The number of babies readmitted to the maternity department within 28 days of birth, from April 2009 to January 2010

Maternal readmissions since April 2009 show no trend either upwards or downwards. Baby readmissions since April 2009 show a gradual increase, however, baby readmissions with feeding problems since April 2009 do not exactly mirror this trend.

Conclusion:
The low numbers involved make it impossible to draw any statistical significance regarding readmissions over this time period.

This data does not suggest that there has been a significant increase in readmissions of either mothers or babies since changes were made in December 2009.

Recommendation:
The Maternity Clinical Effectiveness Committee monitor this information monthly on the Maternity Dashboard system. This information is then escalated to the Trust Board via the "Standards for Better Health / Care Quality Commission" quarterly report. It is recommended that this should continue.

6. NICE Guidance

The guideline 'Routine postnatal care of women and their babies' was issued by the National Institute for Health and Clinical excellence (NICE) in July 2006. The guideline offered recommendations for best practice for midwives and doctors in the provision of postnatal care to all women and their babies.

Derriford Maternity Unit reviewed its compliance with the NICE recommended postnatal care pathway and carried out an audit of practice to monitor compliance.

There is currently no recommended length of postnatal stay for women who have had a caesarean section. The guidelines ask that women be discharged home when they are medically fit and well.

The results from this audit have identified areas of good practice together with some that require further work. Plans of care and management together with documentation of named healthcare professionals scored well. However, less than half of all women were asked about their emotional well being. Midwives need to be reminded to include this in their discussions and evaluations of the needs of women. There was no advice given on the signs and symptoms of potentially life-threatening complications and no discussion on resumption of sexual relationships. This may be addressed by review and redesign of the postnatal checklist in the handheld notes as a prompt to all midwives to cover these important topics. Information re: SIDS could also be included to ensure women receive the necessary information.

It was pleasing to note that all women who chose to breast feed received support and advice. However, this standard must be recreated for women who choose to artificially feed their babies.

Transfer of care from the midwife to the health visitor is well documented and occurred in all cases within this audit.

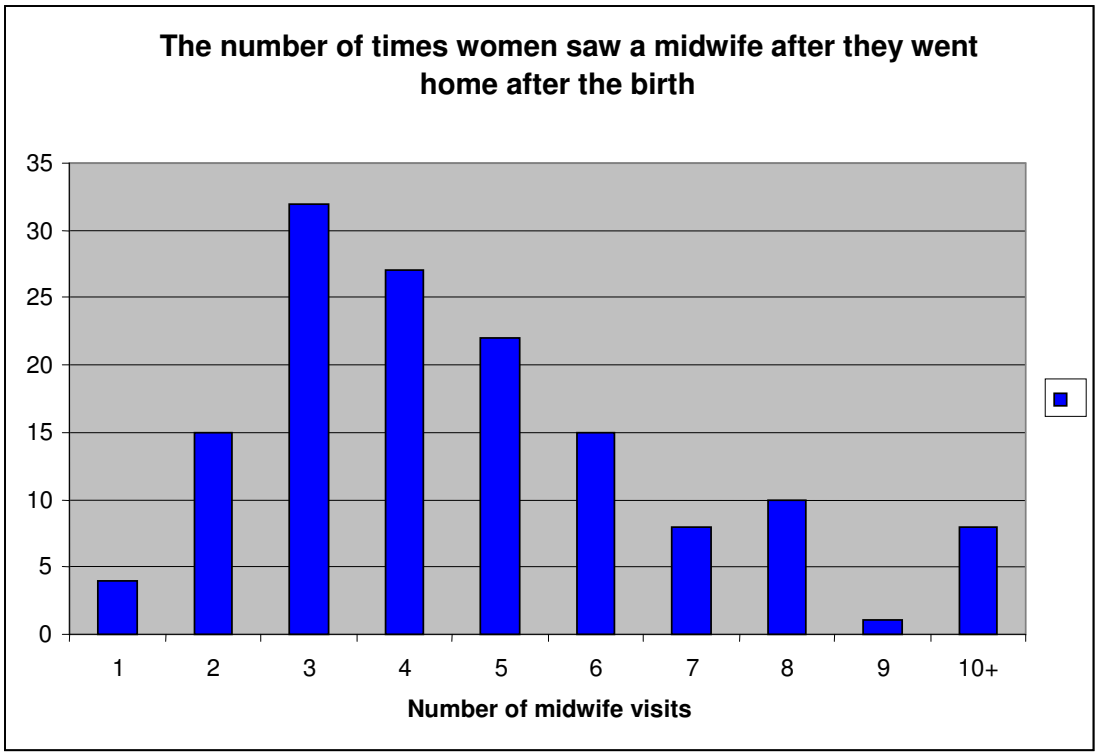
A full copy of this audit is available if requested.

The most recent Maternity Satisfaction Survey showed that 94.6% of women had the name and telephone number of a midwife or health visitor they could contact after the birth of their baby if they were worried.

70.7% of women felt that the length of their stay in hospital was about right. 11.6% felt it was too long, and 10.2% felt it was too short.

The following chart shows how many times in total women saw a midwife after they went home following the birth:

79.6% of women saw a midwife as much as they wanted, 13.6% of women would have liked to have seen a midwife more often and 6.1% of women would liked to have seen a midwife less often.



The above table shows how many times women saw the midwife after delivery. The vertical axis shows the number of women and the horizontal axis shows the number of midwifery visits. It therefore shows that 32 women had 3 or more visits, 26 women had 4 or more visits and 22 women had 5 or more visits.

7. Staff Issues

Sickness

The panel have asked whether there has been an increase in staff sickness rates and how this is being managed.
The Trust Policy on managing sickness is available to all Managers and training days for managers is mandatory. Monthly meetings with the HR team and ward mangers identify those staff that have reached a point of sickness where they need support.
The Trust sickness absence management is fundamentally about good people management.

A Trust monitoring system is used by way of a Performance Dashboard to ensure that Directorates do not have an absence rate of more than 5.25% per month. Managers are asked for assurance that this higher rate of absenteeism is being managed effectively.

The Maternity Unit has had a consistent amount of staff sickness over the months of December, January and February. However this is comparable with the rest of the Trust and has not shown a significant rise.

Winter pressures amongst health care workers are a challenge that we try to manage.

The sickness rates of staff are as follows from December 2009 to February 2010

Month	percentage
December	5.05%
January	4.93%
February	5.28%

This data is comparable with the 3 months sickness rates prior to the changes to Norfolk ward.

Month	Percentage
September	3.28%
October	4.86%
November	5.52%

Attendance management is not an easy process and mangers are supported to be fair and consistent in their approach to managing staff.

Meal Breaks
There is a Midwifery Unit Co-ordinator / bleep holder in the Maternity Unit to provide operational support for any staffing/bed capacity or clinical issues. All clinical shifts have an identified Midwife in Charge who will be responsible for coordinating staff breaks. All staff are told of the importance of taking regular breaks and are actively encouraged to do so. If there is a problem with staffing and staff feel they cannot take a meal break they are aware the Unit Co-ordinator is available for support.

Policies
All Trust wide policies and guidelines can be found on the Trust Intranet. Staff are informed of new polices and changes to policies through the Vital Signs weekly newsletter. All employees have a professional responsibility to use the appropriate channels to inform the Trust of any concerns or issues that have been raised.

8. PALS service

The Patient Advice and Liaison Service (PALS) help to resolve problems and provide information and support to patients, relatives and visitors about health related matters. They will help if you are

- Concerned but don't want to complain
- Have a problem but don't know who to ask
- Worried and not sure what to do

Posters and leaflets advertising the service, with details of how to contact PALS, are on wards and in departments. This information is also available on the website at www.plymouthhospitals.nhs.uk

There are also patient comment boxes which encourage women to give us feedback on the care they have received. These comments are dealt with by the PALS team who then forward them onto the relevant areas.

9. Fathers in the Maternity unit

Whilst we recognise the important role fathers play in pregnancy and birth, sadly there are limited facilities for fathers to stay with their partners. At the moment there are no plans to introduce a fathers' area. However individual consideration is given in exceptional circumstances and there are facilities for fathers to stay on NICU if they have a premature baby.

In the Maternity Satisfaction Survey women were asked about the amount of time their partner was able to spend with them, 98.6% of women had their husband, partner or a companion with them during labour and at the birth of their baby. 89.8% of women had their husband, partner or companion with them for as much as they wanted. These results would suggest that the Maternity Service are supportive as far as they can be in allowing partners to stay outside of visiting hours.

10. Maternity Care Patient Survey

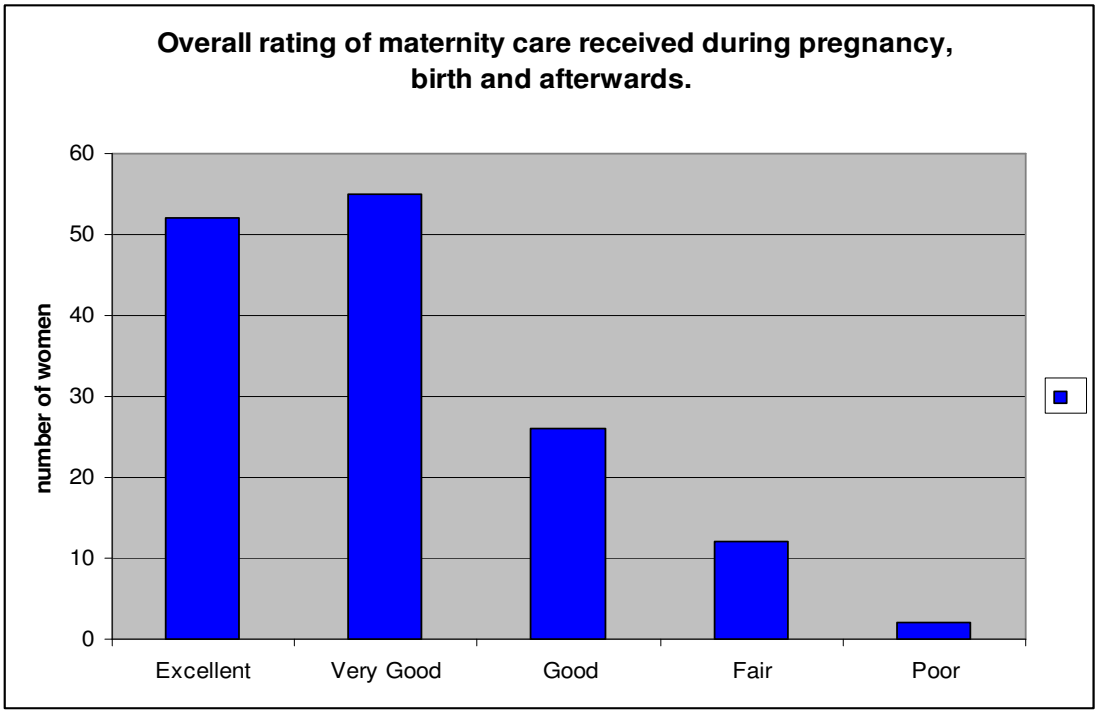
The 2009 maternity patient satisfaction survey was posted to 350 women who gave birth during November 2009, with a pre-paid envelope for its return to the patient services department.

147 completed surveys were returned, giving a response rate of 42%. This is a higher response rate than last year, and a greater number of returned surveys.

The survey was divided into sections and some of the information has been used to compile this report.

The following charts show how women rated their maternity care during pregnancy, birth and afterwards. 90.5% rated their care as excellent, very good or good.

Plymouth Hospitals has recently added a Maternity Unit Virtual Tour to its website to enable women and their families to view the Maternity Unit on line. It contains useful information for women about accessing Maternity services and some important health messages.


Overall rating of maternity care received during pregnancy, birth and afterwards.
number of women
60
50
40
30
20
10
0
Excellent
Very Good
Good
Fair
Poor