Trust Board Paper N

To:	**Trust Board**
From:	**Medical Director**
Date:	**27 June 2013**
CQC regulation:	**N/A**

Title:	Clinical Commissioning Groups Maternity Service Review

Author/Responsible Director: Medical Director

Purpose of the Report: To brief the Board on the outcome of the CCGs' Maternity Service Review.

The Report is provided to the Board for:

Decision		Discussion	✓
Assurance		Endorsement	✓

Summary / Key Points: The attached report has been considered by the Governing Bodies of the three local CCGs during June 2014 – setting out the results of an independent review of maternity services. A verbal report will be made at the Board meeting on next steps.

Recommendations: To note and receive the report and to be updated on the actions which UHL and the three CCGs are taking in consequence.

Previously considered at another corporate UHL Committee?
Executive Strategy Board 7 May 2013.

Board Assurance Framework: N/A	**Performance KPIs year to date:** N/A

Resource Implications (eg Financial, HR):
As set out in the attached report.

Assurance Implications:
N/A

Patient and Public Involvement (PPI) Implications:
Applicable particularly in relation to the future of St Mary's Birthing Centre, Melton Mowbray.

Stakeholder Engagement Implications:
Applicable particularly in relation to the future of St Mary's Birthing Centre, Melton Mowbray.

Equality Impact:
Due regard will be taken of the impact on equality in implementing the report's recommendations.

Information exempt from Disclosure: N/A

Requirement for further review? To be determined

LEICESTER CITY CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

11 JUNE 2013

Title of the report:	Outcomes from Review of Maternity Services in Leicester, Leicestershire and Rutland 2012/13
Author:	Mel Thwaites, Assistant Director of Children and Families Team
Presenter:	Mel Thwaites, Assistant Director of Children and Families Team

Purpose of report:

The Maternity Services Review 2012/13 was commissioned by all three CCGs (Leicester City, East Leicestershire and Rutland and West Leicestershire) and carried out independently, following recognition of a number of issues facing maternity services, including complex demographics and issues around capacity.

The review has found that maternity services are safe and are providing good standards of care across LLR. However, the review also found that despite the hospital redeploying staff and directing mothers to other labour wards when needed, services at Leicester Royal Infirmary and Leicester General Hospital can become over-stretched during busy periods and recommends reviewing the number of midwives, doctors, support staff and bed capacity.

A total of 49 recommendations have been identified by the review, most of which relate to operational issues to be addressed by University Hospitals of Leicester's (UHL),There are also a number of commissioning and contracting recommendations that are already being addressed by the CCGs. It also identifies four key priority recommendations that will need the hospitals and the Clinical Commissioning Groups (CCGs) to work together on. These include:

- A review of the services in the Melton area including the services provided at St Mary's Birthing Unit
- Revisiting plans for a new single-site maternity hospital
- Increasing the number of midwives
- Improving training and support for the obstetrics team

This paper sets out a summary of the review findings and the proposed next steps for the CCGs as commissioners.

Actions required by the Governing Body members:

RECEIVE the report

ACCEPT the recommendations

AGREE the approach for delivering on the recommendations.

AGREE the CCGs' duties to ensure appropriate Due Regard and therefore, the need for an Equalities Impact Assessment and to facilitate meaningful public consultation where required.

Outcomes of the external Review of Maternity Services 2012/13

INTRODUCTION

1. The purpose of this paper is to update the governing body on the outcomes of the external commissioner-led review of maternity services (full report attached).

2. This review was commissioned by the three local Clinical Commissioning Groups (CCGs)in order to ascertains whether the service is providing safe high quality care, in recognition of a number of issues facing the maternity services including complex demographics and capacity .

3. It was also agreed that this review would consider the current commissioning arrangements to ensure they are robust.

THE REVIEW

4. It was agreed that the review would be undertaken by an externally commissioned team led by a Midwife and Obstetrician. Governance would be by a task and finish group chaired by the City CCG Co-Chair, Dr Avi Prasad.

5. Due to the depth and breadth of this review it was agreed that it would be undertaken in four phases:
    - Phase One - To review outcomes of recent reviews/ enquiries
    - Phase Two – To review clinical policies and care pathways and adherence to NICE guidance
    - Phase Three - To undertake Site Visit and interviews with staff
    - Phases Four – To review commissioning arrangements including Contracting , Commissioning and Quality

KEY FINDING OF THE REVIEW

6. Evidence gained by the review indicates that the maternity services provided by Leicester hospitals are safe and are providing good standards of care. However, the review also found that that quality of patent experience during busy periods did suffer despite the hospital redeploying staff and directing mothers to other labour wards when needed and recommends reviewing the number of midwives, doctors, support staff and bed capacity.

7. It also found that there is a well-trained and well-motivated team of midwives and support staff who feel supported by the new Management Team within maternity services at UHL and there was no evidence of unsafe or substandard midwifery practice.

8. The report also highlights the need to review the services provided in the Melton Mowbray area including St Mary's Birthing Unit; due to the low numbers of births within the unit, the distance between Melton Mowbray and acute services and the cross over between home birth services and Melton Birthing Unit.

9. Another issue highlighted by the review, relates to leadership and capacity within obstetrics. The report indicates a need to strengthen training and to improve support and leadership for the medical team.

10. In relation to commissioning, the report states that overall there are structures in place to ensure the commissioning of maternity services is safe and effective. However it recommends enhancing GPs engagement within the contracting process.

11. The review has identified 49 recommendations in total, the majority of which are operational issues which need to be addressed by UHL. There are also a number of commissioning and contracting recommendations that are already being addressed by the CCGs. Actions plans have been developed to address these recommendations and they are being monitored and delivered by the joint UHL and CCGs strategy group for Women's and Childrens services. However, there are four key recommendations that need involvement from both UHL and CCGs, these and the recommended next steps for addressing them are listed below.

KEY RECOMMENDATIONS AND NEXT STEPS

12. **St Mary's Birthing Centre in Melton Mowbray (Recommendation 3)**
    The report suggests that St Mary's Birthing Centre in Melton Mowbray may not be sustainable due to low number of births that occur there and its geographical location. The birthing unit is much valued by those women who use it and the CCGs will not be proposing any changes until we have explored the issues raised in the review and taken into account the views of patients and the public.

    ACTION; ***Commissioners to lead a piece of work with UHL to*** **review** ***the services currently provided in the Melton area***

13. **Ensure that plans for a completely new hospital are revisited and that the Interim Solution does not become the Final Solution (Recommendation 10)**
    Following the NSR of maternity services (2010), the PCT and UHL boards agreed to recommend the clinically preferred option to work towards establishing a single site new build for maternity services across LLR. However it was recognised that this was a long term solution and would not be achieved in the short term due to the current financial climate. It was therefore agreed that an interim solution would be developed that would be based on using the current estates as efficiently and effectively as possible. The implementation of this interim solution is now underway and will result in the increase number of delivery rooms, expanding the neonatal unit and increasing the numbers of midwives. A one-site solution remains unaffordable at the present time. Despite this the CCGs are keen to continue to pursue a single site solution in the long-term and plan to ensure this stays high on the agenda.

    ACTION; ***CCGs to ensure that infrastructure solutions remain high on the work stream agendas***

14. **Continue to work towards improvements in the funded establishment of midwives to provide a ratio of midwives to women of a maximum of 1:28 (Recommendation 13)**

The PCTs undertook significant work to improve the midwife-to-birth ratio and have increased investment to UHL for the past three years. The CCGs will continue to work with Leicester's hospitals to improve the funded establishment of midwives through the implementation of the new maternity pathway tariff, and plan to agree a local midwife to birth ratio recognising that the 1:28 is an ambition. This will be monitored and delivered via the contract process and the Commissioning Collaborative Board.

ACTION: ***The CCGs will continue to work with Leicester hospitals to improve the funded establishment of midwives and plan to agree a local midwife to birth ratio recognising that the 1:28 is an ambition*** **.**

15. **Addressing the issues in relation to Obstetrics (Recommendations 16-25)**
There are several recommendations which relate to training, support and leadership for the medical team. These issues are operational issues for UHL to resolve. However commissioners will seek assurance that they are addressed via the quality and contracting process.

ACTION; I*ssues in relation to obstetrics will be delivered by UHL however commissioners will seek assurance that they are addressed via the quality and contracting process.*

CONCLUSIONS

16. The outcomes of the review indicate that maternity services are safe and are providing good standards of care across LLR. However, the review also found that despite the hospital redeploying staff and directing mothers to other labour wards when needed, services at Leicester Royal Infirmary and Leicester General Hospital can become over-stretched during busy periods and recommends reviewing the number of midwives, doctors, support staff and bed There is also a need for UHL to strengthen the training and improve support and leadership for the medical team.

17. The review has identified 49 detailed recommendations, the majority of which are operational issues which need to be addressed by UHL. There are also a number of commissioning and contracting recommendations that are already being addressed. Actions plans have been developed to address these recommendations and they are being monitored and delivered by the joint UHL and CCGs strategy group for Women's and Childrens services. However there are four areas that need involvement from both UHL and CCGs.

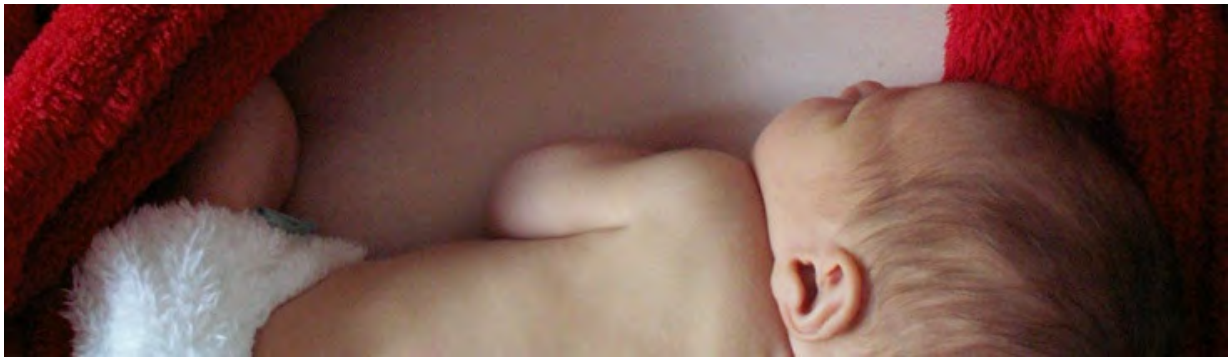
18. It is recommended that the issues around estates need to be high on the work programme agenda; that the two priorities around obstetric and midwifery staffing are delivered via the contracting process and that any proposals for service change have public and patient engagement as core components.

19. It is also important to note the CCGs' duties to ensure appropriate Due Regard and therefore, the need for an Equalities Impact Assessment. The CCGs also have a duty to ensure appropriate communications and engagement to help patients, the public and our stakeholders, understand our response to the findings of the review and to facilitate meaningful public consultation where required.

RECOMMENDATIONS:

Actions required by the Governing Body members:

RECEIVE the report
ACCEPT the recommendations
AGREE the approach for delivering on the recommendations.
AGREE the CCGs' duties to ensure appropriate Due Regard and therefore, the need for an Equalities Impact Assessment and to facilitate meaningful public consultation where required.



Maternity Service Review at

University Hospitals of Leicester NHS Trust

2012-2013

Toby Fay – Obstetrician
Liz Mair – Commissioner
Chris Sidgwick – Midwifery Advisor
Amanda Sullivan – Commissioner

Commissioned by Leicester City Clinical Commissioning Group, West Leicestershire Clinical Commissioning Group, and East Leicestershire and Rutland Clinical Commissioning Group

CONTENTS

ACKNOWLEDGEMENT

The four Reviewers are grateful for, and acknowledge, the help and cooperation of Trust personnel at all levels who were welcoming in their attitude and open and honest during the interview process.

1. EXECUTIVE SUMMARY

1.1. This Review, commissioned by the newly forming Clinical Commissioning Groups (CCGs) across Leicester, Leicestershire and Rutland (LLR), was undertaken by an Obstetrician, Midwifery Advisor and two Commissioners. All four Reviewers were from outside Leicestershire and provided independent opinions pertaining to the quality, safely, commissioning and contracting of maternity services provided by the University Hospitals of Leicester (UHL) NHS Trust.

1.2. Although the Review was independent in nature the CCG Task & Finish Group formulated the Phased Implementation Plan to which the Reviewers worked.

1.3. The Trust provides maternity services for LLR covering a geographical area of 73.3 square kilometres within 3 distinctly different areas with differing health needs. The greatest needs are in the inner city area which has higher than national average rates of perinatal mortality, infant mortality, poverty and lone parents.

1.4. A full range of maternity services are provided for approximately 11,000 women across 3 sites: Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and St Mary's Birthing Centre. All pregnant women are risk assessed at booking and their care pathway determined by their medical and/or social needs.

1.5. **Phase One,** a desktop exercise carried out by the Midwifery Reviewer, was to review the reports and documentation of 7 previous reviews carried out between October 2010 and August 2012.

1.6. The information in the documents did not clearly quantify specific clinical issues but in general terms the service was not found to be wanting to any significant degree.

1.7. **Phase Two,** also a desktop exercise, was jointly undertaken by the Obstetric and Midwifery Reviewers who considered clinical policies and pathways, Serious Untoward Incidents (SUI), the Divisional Management Structure and the Women's Services Clinical Business Unit (CBU) Structure.

1.8. The clinical policies and pathways were well written, appropriately and well referenced and all of the 16% examined in detail were found to be in accordance with available national guidelines and good practice.

1.9. The Divisional Management Structure appeared to be satisfactory with appropriate clinical leadership. However within the Women's Services CBU an anomaly appears to be the inordinate responsibility for the head of Midwifery (HOM)/Lead Nurse who is also Service Manager for Maternity who in addition has the responsibility as a Supervisor of Midwives. (SOM)

1.10. Risk recognition and reporting mechanisms are good and actions relating to audit, staff training, policies and system adjustments are timely and effective.

1.11. There is a multidisciplinary approach to risk management which is sound but there are weaknesses in both quality and safety which are consistently those of staffing and capacity.

1.12. **Phase Three** was jointly undertaken by the Obstetric and Midwifery Reviewers and involved a two week period of on-site visits and staff interviews.

1.13. The in-patient wards at the LRI and LGH provide antenatal and postnatal care and were very busy at every visit and there were frequently periods when there were no beds available for newly delivered women. The women who talked to the Midwifery Reviewer on her frequent visits were however happy with their care and there was a very positive attitude of camaraderie among staff who were rising to the challenges of the day.

1.14. Both Delivery Suites/Labour Wards were also very busy and there were occasions when women delivered in the Maternity Assessment Centre (MAC) because the designated delivery rooms were all occupied.

1.15. Because of the high workload and the availability of midwives low risk women rarely receive one-to-one care in labour.

1.16. The Early Pregnancy Assessment Unit (EPAU) is a self-contained, well run unit which functions Monday to Friday from 08.30 to 17.00 hours and on most Saturday and Sunday mornings. The Reviewers had no concerns or recommendations regarding this service.

1.17. Neonatal services are provided on both the LRI and LGH sites. LRI is classified as a Level 3 unit which provides the full range of neonatal care from Special to Intensive Care. LGH is classified as a Level 1 unit and only provides Special Care. Both units exceeded capacity on occasions but this is a common occurrence throughout the UK and there is a National Neonatal Network and transport system which is used to facilitate transfer of care. The Reviewers had no concerns or recommendations regarding the service.

1.18. The St Mary's Birthing Unit in Melton Mowbray is a facility for low risk women to deliver their babies in a homely environment. The Building is old, shabby and in need of renovation, the service is so underused that it is unsustainable and there are no services provided in St Mary's which could not be provided by the Community Midwives in the homes of women who are low risk and request midwifery led care.

1.19. There were several recurring themes from interviews, enquiries and observations. UHL became a Trust as a result of a merger of three separate organisations. The Maternity Services are now 'one service on

two sites' which still has challenges relating to standardising services for women and instilling a sense of corporate loyalty into staff who have, in the past, been loyal to only one hospital base.

1.20. There is a need to strengthen stability, training and improve support and leadership for the medical team which has been adversely affected by the Trust's focus on managing the Interim Solution and the disproportionate number of locum doctors who, understandably, do not share a corporate loyalty to the Trust.

1.21. There is a well-trained and well-motivated team of midwives and support staff who in general feel supported by the new Management Team and there was no evidence of unsafe or substandard midwifery practice.
The services which are hospital based are stretched to the limits because of increasing activity and there is a need for more midwives, doctors, support staff and bed capacity.

1.22. The Reviewers have formed the opinion that the service is safe most of the time but the risks associated with suboptimal staffing and a shortage of beds are high and, though actively managed by transferring activity, often result in poor quality of care to women during frequent busy periods.

1.23. Structures and strategies are in place to deliver a first-class service however this will not be deliverable until the shortfalls are addressed.

1.24. The Interim Solution will improve the bed situation but even when work is completed the service will have fewer beds available across both sites than in 2004. Both Reviewers are concerned that the Interim Solution may become the Final Solution and all efforts should be made to avoid this happening.

1.25. **Phase Four,** the review of commissioning and contracting of maternity services was carried out by the two Commissioning Reviewers who concluded that there are structures in place to ensure the commissioning of maternity services is safe and effective. Maternity services do not appear to have much specific focus in terms of discussion about the whole UHL contract and are not seen as an area of high concern in terms of contract management. This may be because national high profile targets and activity management dominate overall discussions.

1.26. There is a clear distinction between the contracting function and broader strategy/commissioning activity. This was built into the CCG design, but it may be appropriate to now review structures and to mainstream maternity reviews with other CCG governance processes and decision-making processes regarding service redesign. Some of the informal relationships between leads need to be formalised and delivered through the developing structures.

1.27. Implementing the new tariff will bring with it challenges and will require robust information systems in place to ensure correct money flow for local women and women who deliver out of area. Several of the issues previously seen (e.g. NZ activity and coding the delivery of parent craft) will no longer be issues with the full implementation of tariff.

1.28. There was good evidence of undertaking actions to respond to quality issues in a responsive way (CTG reporting) and internally the Maternity Division is seen as one of the most transparent in terms of reporting serious incidents and near misses. This is thought to be because of the high NHS Litigation Authority insurance premiums paid for maternity services. Community midwifery services do not appear to undergo the same level of scrutiny as hospital-based practices.

1.29. The Reviewers have made 49 detailed recommendations to address and improve areas of concern.

2. INTRODUCTION

2.1. Over the last 3 years significant work has been carried out in relation to improving and maintaining quality and ensuring a safe and sustainable maternity service.

2.2. There have been 6 reviews over the past 2 years in which the maternity service of the University Hospitals of Leicester (UHL) NHS Trust has been examined and assessed, all of which have given positive assurances regarding safety and quality.

2.3. The Commissioners are seeking further assurances in the light of the Serious Incident (SI) reports originating in the service and a recent incident which was widely publicised in the local press. To that end the Commissioners engaged the services of four independent reviewers: Consultant Obstetrician, Midwifery Advisor (Lead Reviewer) and two Independent Commissioners to conduct a commissioner-led maternity service review. The two Clinicians will examine and assess the clinical aspect of quality and safety and the two Commissioners will provide a description and evaluation of the strategic development, commissioning and contracting of maternity services undertaken by the newly forming Clinical Commissioning Groups (CCGs) across Leicester, Leicestershire and Rutland (LLR) and the UHL NHS Trust.

3. TERMS OF REFERENCE

Maternity Services: Review of commissioning and provider issues to provide assurance to Leicester and Leicestershire CCGs of the quality and safety of the services.

Background to the Review

Over the last 3 years significant work has been carried out in relation to improving and maintaining quality and ensuring a safe and sustainable maternity service. This has resulted in significant investment in midwifery, neonatal and other obstetric services. However the services still face real challenges in relation to demographic issues especially in the city and more generally in relation to capacity of the services to cope with increasing demand and complexity. The maternity facilities in UHL were designed to cater for approximately 8500 deliveries per year, but deliveries now total approximately 11,000 per year.

In 2010 the whole health community agreed, through the Next Stage Review, that the solution would be of a single site maternity and neonatal service based at the LRI site, with up to two community birthing facilities. However because of financial constraints an interim solution was adopted as a cheaper but short-term alternative to implementing the preferred long term solution. When fully implemented this interim solution will help to address some of the current issues.

Recent Reviews and Benchmarking:

Maternity services are rightly under constant scrutiny and UHL maternity services have been inspected, reviewed, and benchmarked on several occasions in recent years. Relevant recent reports include:

- SHA Review and Thematic Analysis of Maternity Never Events 2011/2012; 2012/3 (Q1). August 2012 (good practice noted).
- CQC inspection June 2012 – fully compliant.
- Local Supervisor of Midwives Authority Annual Visit: June 2012. Awaiting report but no problems identified and improvement noted from previous reviews
- Commissioner / SHA Review of 3rd/4th Degree Tears; Blood loss; and CTG interpretation: May 2012. Suitable assurance given. (Dashboard targets considered unrealistically ambitious and reset.)
- SHA Appreciative Enquiry April 2012 – no concerns in maternity services.
- Foundation Trust Network Maternity Benchmarking Exercise October 2011. (previously undertaken in 2007)
- Clinical Negligence Scheme for Trusts Assessment: October 11. Passed level one assessment with score 49/50.

In addition the Trust has responded to the following CQC outlier alerts; both of which have been closed by the CQC as the Trust has provided satisfactory assurance:

- Puerperal sepsis Sept 2011 - closed
- Perinatal mortality July 2010 – closed

The Need for a Further Review:

Despite the above, local commissioners seek further assurances about local maternity services, to address concerns in 2 areas:

1) Is the service providing safe, high-quality care with appropriate governance?
2) Are local commissioning arrangements properly supporting the service in terms of (a) resource, and (b) monitoring quality and safety?

Reasons for commissioners seeking this further assurance include:

- Continuing concerns by the commissioners'' governance team in relation to Serious Incidents (SI) reports originating in the service;
- Recent damaging publicity caused by a specific case, in which a moderate incident had to be escalated to a Serious Incident because of publicity (rather than the incident itself) and to which the Trust was unable to respond because of patient confidentiality.

In this context it has been agreed that a commissioner led review will be commissioned to provide further assurance to the Leicester, Leicestershire and Rutland CCGs of the quality safety and effectiveness of the services, and to review the current commissioning arrangements to ensure they are robust. This review will be undertaken by an externally commissioned team and will focus on provider and commissioning issues.

Scope of the Review:

1) To ascertain whether the service is providing safe, high-quality care with appropriate governance?
The following services are to be considered:

- Acute and Community Midwifery
- Maternity including Obstetrics, Midwifery, Obstetric Anaesthetics and associated services
- St Mary's Birthing Centre, Melton Mowbray
- Antenatal and postnatal pathways
- Delivery pathway
- Early Pregnancy Services

2) **To establish whether** local commissioning arrangements are properly supporting the service in terms of (a) resources and (b) monitoring quality and safety?

3) To review:
CCGs Governance Mechanisms and decision making processes

- Commissioning resource and knowledge
- Method and approach to commissioning of quality

In relation to the above the following issues will be looked at in detail and will form an integral part of the review:

- Review of the local maternity service provision paying particular attention to the capacity of the service, clinical risks, workforce, skill mix, locations, safety, pathways and quality of service, outcomes and satisfaction.

- Review the demographic issues especially in the City to look at how health inequalities impacted on services demand and complexity.

- The way in which Maternity Services are commissioned and quality assured including CCGs governance mechanisms knowledge and decision making processes, and method and approach to commissioning of quality.

- A review of current best practice methods of maternity services paying particular attention to the clinical risk, workforce, skill mix, locations, safety, and quality of service, outcomes and satisfaction, including benchmarking data.

- Review of reporting structure from maternity services to Trust governance processes in relation to the reporting of serious incidents and the learning opportunities

- Review of clinical policies and procedures including appropriate review and local implementation of NICE guidance.

- Review outcome of the NSR on Maternity Services in order to re-consider the recommendation in light of current issues and to ensure the proposed interim solution is still appropriate.

Exclusions

The review will not include the following services:

- Gynaecology except for Early Pregnancy Services
- Assisted Conception
- Infertility
- Neonatal

Governance

This review will be commissioner led, but conducted in partnership with UHL.
An externally team will be commissioned to undertake the review

A task and finish group will be established chaired by Dr Avi Prasad on behalf of the three CCGs. The group will be responsible for:

- Developing Scope and TOR of the review
- Appointing and supporting external review team
- Developing content and timescale of the review

- Producing report following completion of review including recommendations / next steps

The task and finish group will consist of the following members:

- Senior Responsible Officer
- Commissioning Lead
- Clinical & Managerial Lead of – Maternity services UHL including Divisional Director, CBU Clinical Lead, CBU General Manager, Head of Midwifery
- GP leads for the CCGs
- UHL contracts lead.
- Cluster representative
- SHA representative
- Communication /PPI representative? TBC
- Quality representative
- Finance representative TBC
- Other member to be co-opted as required.

The task and finish group will report directly to the Commissioning Collaborative and from there the appropriate individual organisational Board structures.

4. METHODOLOGY

4.1. Although the Review was independent in nature the CCG Task and Finish Group formulated a phased implementation plan. (See table below) Phase one was a desktop exercise reviewing recent review reports which was undertaken by the Midwifery Reviewer; Phase Two, also a desktop exercise was to review UHL clinical policies and care pathways which was undertaken jointly by the Midwifery and Obstetric Reviewers; Phase Three was a period of on-site observations, discussions and interviews with Trust staff undertaken jointly by the Midwifery and Obstetric Reviewers and Phase Four was the review of the Commissioning of Maternity Services undertaken jointly by the Commissioning Reviewers.

4.2. **Maternity Review Phased Implementation Plan**

Due to the depth and breadth of this review it will be necessary to undertake it in four phases. The table below identifies the four different phases and the element within each.

Phase	Tasks to be undertaken
Phase one Desktop Exercise	**To review outcomes of recent reviews including the following** • NSR Maternity and Neonates Review • Appreciative enquiry • CQC Inspection • Review of Quality Issues in relation to Blood loss, perineal tears and CTG interpretation • OBC and options appraisal for Interim solution **To review outcomes of the above reviews and make recommendation as to whether they are still appropriate**
Phase Two Desktop Exercise	**Review of clinical policies and care pathways** • To review UHL clinical policies and pathway and to compare to NICE guidance and Best Practice • Review of Serious untoward incidence and compare benchmark against similar trusts

	• Review Governance / Management and clinical leadership structures and how theses interface with wider UHL senior management team
Phase Three Site Visit	**External Review team to undertake Site Visit and interviews** Observer services pathways in action on • delivery suite / theatre • wards • community Interviews with staff
Phases Four Review of commissioning	**Review commissioning of maternity services** • CCGs Governance Mechanisms and decision making processes • Knowledge and Commissioning Resource • Method and approach to commissioning of quality • Use / implementation of National tariffs • Detail services specifications within acute contract

5. SERVICE DESCRIPTION

5.1. The Trust provides a full range of maternity services for approximately 11,000 women, the majority who live in the Leicester City, Leicestershire and Rutland (LLR) area. Services are provided on three sites, the Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and St Mary's Birthing Unit. In addition 10 teams of Community Midwives and Maternity Care Assistants (MCA) deliver antenatal and postnatal care in women's homes, clinics and children's centres across LLR as well as supporting a Homebirth Service.

5.2. Pregnant women have a full history taken by the Community Midwife for their geographical area, the new notes are then sent to Pregnancy Assessment where they are risk assessed and a care pathway determined by their medical and/or social needs.

6. DEMOGRAPHICS

6.1. The Trust provides maternity services for Leicester City, Leicestershire and Rutland (LLR) covering a geographical area of 73.3 square kilometres. Within the total are three distinctly different areas (Appendix 1) with differing health needs with the greatest needs being in the inner city area.

6.2. Leicester City has higher than nation average rates for perinatal mortality, infant mortality, children living in poverty, lone parent families, general fertility rate and teenage conceptions whereas Leicestershire and Rutland are lower than the national average for all these indicators except for perinatal mortality. In addition 58.3% of mothers in Leicester City are in a BME group (many whose first language is not English) compared with 16.3% for Leicester County and Rutland.

6.3. The number of live births in LLR in 2010 was 12,709.* This is predicted to rise to 13,700 in 2012 with a slight fall in 2021 to 13,400. Not all women living within the LLR boundaries deliver in LRI, LGH or St Mary's (i.e. under the care of the Trust) and many of the women who deliver outside of the boundaries receive antenatal and postnatal care provided by the Trust's Community Midwives.

6.4. Information relating to the demographics was obtained from the Speciality Registrar in Public Health using SPSS v 17.

- **Not all babies were delivered under the care of UHL who's deliveries in 2012 were predicted to be circa 11,000.**

7. PHASE ONE

To review outcomes of recent reviews.

This desktop exercise was undertaken by the Midwifery Reviewer and completed on the 8th October 2012.

Documents reviewed:

- Maternity and Neonatal Services Next Step Review (NSR) - October 2010
- Foundation Trusts Network Benchmarking Workshop - March 2011
- Midlands and East Strategic Health Authority (SHA), Appreciative Enquiry - May 2012
- UHL Supervisors of Midwives Review of 3rd and 4th Degree Tears - April 2012
- Review Meeting Notes (specifically relating to CTG (fetal monitoring) interpretation) - May 2012
- UHL Interim Solution for Maternity & Gynaecology Services Outline Business Case (OBC) - July 2012
- Care Quality Commission (CQC) Inspection Report - August 2012

7.1. Maternity and Neonatal Services NSR dated 6th October 2010 – 12 pages

The object of this report was to *'guide the delivery of a series of actions related to the production of a robust business case aimed at improving maternity and neonatal services'* (Page 2:6)
As the remit of the Midwifery and Obstetric Reviewers is to examine the safety and quality of the maternity services there are a number of issues raised in this report which will need to be covered in the review process. Four of the *'current risks'* i.e. Delivery Suite capacity, Postnatal Ward capacity, low medical staffing and low midwifery staffing will be examined during the review process and any improvements reported.
From a quality perspective patient satisfaction is important and this report details a stakeholder engagement exercise in 2009. The Reviewers will want to see evidence to show how the feedback from that exercise (page 3:12) is shaping the service delivery. Also the Reviewers will want to see any further satisfaction surveys undertaken in the past two years.
In the light of the current financial climate the Phased Interim Solution appears workable and, as Phase Three is due to be completed by March 2013, the Reviewers will want to see evidence of progress.
On page 8 number 50 are details of a plan to maintain the midwifery establishment at a minimum ratio of 1/33 midwife to births. There has been extensive work undertaken recently by Birthrate Plus using a workforce planning tool to estimate accurately the number of midwives needed to provide safe maternity care, including one to one care for women in labour. The Reviewer is of the opinion that, taking into consideration Leicester's areas of deprivation and the complexity of maternity cases that the ratio should be a maximum of 1/28. Further exploration of this issue will be covered in the Final Report.

7.2 Foundation Trusts Network Benchmarking Workshop dated 3rd March 2011 – 124 pages

There were 16 participating Foundation Trusts from Gateshead and Sunderland in the north of England to Devon and Exeter in the south of England. University Hospitals of Leicester was identified in the exercise as UHL and, as one of the largest trusts, was compared in Cohort A with 7 other trusts with the highest number of deliveries annually.

The number of deliveries quoted for UHL was 5,436. The Reviewer clarified with the Head of Midwifery (HOM) that the data used in the Benchmarking Exercise was for a 6 month period.

UHL had the highest number of deliveries in the cohort i.e. 5,436 compared with Liverpool with 4,371, East Kent with 3,808, Guys and St Thomas with 3,301, Calderdale & Huddersfield with 2,948, Worcester with 2,911 and University College London with 2,813.

Considering bed capacity, although UHL had significantly more deliveries than the other trusts, it had only the 3rd highest number of beds.

Considering the risk percentage profile, UHL was the 3rd highest for diabetes, 3rd highest for severe obesity, highest for hypertensive disorders, 3rd highest for pre-existing vascular and heart disorders, 2nd highest for poor obstetric history and highest for epilepsy.

There were significant differences between pregnancy outcomes but the trusts were only identifiable by code and so the Reviewer cannot comment on this aspect of the exercise.

UHL had the lowest percentage of Caesarean sections at 22% and was lower than the national average which is highly commendable.

UHL had the second highest ratio of midwife to deliveries at 1/35 which confirms the previously identified need to significantly increase the midwifery establishment.

There was significant variation in daily deliveries per bed across the trusts and UHL had the highest at 0.9 compared with Liverpool at 0.7, London & Kent both at 0.6, Guys & St Thomas and Worcester both at 0.5 and Calderdale & Huddersfield at 0.4. This appears to indicate that there could be an issue around capacity.

There was a section identifying percentage rates of 3rd and 4th degree tears and readmission rates to hospital but this data was coded and so the Reviewer cannot comment on this aspect of the exercise.

Overall UHL benchmarked favourably compared to other similar sized trusts.

7.3 Midlands & East SHA Appreciative Enquiry dated 18th May 2012 – 43 pages

This enquiry took place as part of the SHA regular systematic review of services. The Appreciative Enquiry (Quality Assurance) is '*a form of rapid investigation based on a broad review of clinical services and active engagement with patients and staff to assess the standard of clinical services provided'.*

The enquiry was Trust-wide i.e. not focused on, but including, the maternity services and the team visited 42 clinical areas over 3 hospital

sites. They reported: *'No immediate patient safety risks were found during the visit'.*

Many of the concerns identified were around the Emergency Department and the Acute Medical Unit and the '*Trust's lack of articulated vision and clinical strategy risks inhibiting improvements in clinical care'.*

One area of concern relating to the maternity services was the perinatal mortality rate which was *'not as good as expected'.* This would be noted in the SHMI which was recorded as one of the '*top worries*'. Both of the Reviewers will be examining the outcomes of pregnancy and comparing the Trust's data with regional and national data.

The other area of concern which could relate to the maternity services was the *'Lack of clear escalation policy for times when capacity is overwhelmed'.* (Page 12) The Reviewers will examine the maternity service escalation policy and its use during the review process.

Recommendations 6.5 and 6.6 relating to morbidity and mortality multidisciplinary meetings are already on the Reviewers list to examine.

7.4 UHL Supervisors of Midwives (SOM) Review of 3rd and 4th Degree Tears dated April 2012 – 10 pages

This review of midwifery practice was triggered by a Red RAG rating on the Maternity Dashboard for 3rd and 4th degree perineal tears of 3.5% of total deliveries. The Dashboard Rating for perineal tears is:

Less than 2.3% = green

2.3% to 2.5% = amber

Greater than 2.5% = red

The SOMs, whose role it is to protect the public, conducted a snapshot audit of midwifery practice and during that period of time none of the women who delivered sustained 3rd or 4th degree tears and no unsafe practice was noted.

In the action plan, which followed on from the audit, (page 4) the SOMs were to develop Best Practice Workshops for midwives and there was to be an on-going monitoring of perineal trauma.

This piece of work was an excellent example of how midwifery practice can be improved through peer review, audit and education.

Perineal trauma does not only occur during normal deliveries but there are increased risks also associated with instrumental deliveries carried out by medical practitioners, prolonged labour and the general health of the women. Further investigation needs to be undertaken into not only the number of 3rd and 4th degree tears but also in identifying the mode of deliveries and the status of the lead clinicians attending to women who sustain the tears. The Reviewers will examine the Maternity Dashboard covering the last 3 years: particularly focusing on Red RAG Ratings.

7.5 Desk Top Review of Maternity Services. Meeting dated 21 May 2012 – 4 pages

The purpose of the meeting was to seek further assurances regarding 3rd and 4th degree tears, blood loss and CTG interpretation. Perineal tears have already been covered at 4 above.

There was insufficient information regarding 'blood loss' for the Reviewer to understand the issue e.g. *'IS confirmed that the Trust's Policy of 1ml haemoglobin is utilised'*

During the discussion it was agreed that CBU would undertake an audit against their own pathway to ensure that mothers who had moderate blood loss were followed up appropriately. The Reviewers will follow up this agreed action during the review process.

CTG interpretation is a very inexact science and the Reviewer has seen, over her years of clinical midwifery practice, many babies born in good condition with high APGAR scores where there has been a poor CTG trace during labour and delivery. Equally she has seen many babies born in poor condition with low APGAR scores where the CTG in labour and delivery has been within normal Limits.

It was reassuring to note that the pass level, during the assessments in CTG training sessions, has been increased to 75%, that CBU are implementing master classes for clinicians and that both the SOMs and Consultant Obstetricians will be reviewing misinterpretation and classification of CTG tracings.

The Reviewers will look for evidence of training and improvement in classification and interpretation during the review process.

7.6 UHL Interim Solution for Maternity & Gynaecology Services – Outline Business Case (OBC) dated 26 July 2012 – 78 pages

This is a complex document detailing an extensive piece of work carried out by an external commercial consultancy; the Executive Summary covers 18 pages and much of the report covers business and finance of which the Reviewer has limited experience.

It is noted on page 2 at 1.1.8.that the long term aim of the Trust is to provide maternity services from one site and not at LGH. The Reviewer would question if a public consultation had been considered in the light of the national focus (Government, NGOs and professional bodies) on choices for women and their ability to access services locally.

On page 4, at 1.2.7., there are 4 identified risks: lack of maternity service capacity, sub-standard obstetric theatre environment, lack of scanning capacity and low midwifery and obstetric staffing levels. All these issues are pertinent to safety and quality and therefore will be examined by the Reviewers during the review process.

In the Summary of Key Issues on page 6 at 1.3.4., most of the 10 issues will also be examined by the Reviewers.

Within the body of the OBC there is a Long List of 14 detailed options to improve and enhance service provision; this was reduced to a Short List of 5 options at a workshop in April and the Reviewer understands that none of the options listed in the document will be taken up, due to financial constraints, but that the options will be further considered at a time when the finance is available to proceed.

7.7 Care Quality Commission (CQC) Review of Compliance dated August 2012 – 33 pages

The CQC carried out the review as part of the routine schedule of planned reviews. This review was not Trust-wide but involved inspection of all service areas on the Leicester Royal Infirmary (LRI) site.
During the on-site visits on the 27th and 28th June 2012 inspectors spoke to a number of patients, family members and carers on the maternity wards, the Emergency Department (ED) and planned care wards. Patients were complimentary about treatment received and most patients had not expressed any concerns.
Of the 9 standards reviewed the Trust was found to be compliant with 6 and noncompliant with 3 and the standards in the document are expressed as outcomes.
Outcome 1: Respecting and involving people who use services – The Trust was compliant and there was no mention of the maternity services.
Outcome 4: Care and welfare of people who use the services – The Trust was compliant and the inspectors noted complimentary comments made by 2 sets of parents of newborn infants (probably in the Neonatal Unit). On the day of the inspection the Maternity Unit was very busy and closed for further admissions and women were being transferred directly to the LGH because of capacity issues. Maternity staff were able to satisfy the inspectors about the interim solution and communicating liaison arrangements with professionals in the Community. Staff also reported an encouraging rise in the number of women breastfeeding their babies.
Outcome 7: Safeguarding people who use the service from abuse – The Trust was found to be compliant. The inspection team observed maternity staff checking visitors' identities and reported that maternity staff had a comprehensive understanding of safeguarding issues. Specialist midwives, who were employed to support vulnerable groups of women, worked with other outside agencies to safeguard patients.
Outcome 9: Management of Medicines - The Trust was found to be non-compliant but no specific mention was made of the Maternity Department. In the light of this the Reviewers will take particular note of the management of medicines during the review process.
Outcome 13. Staffing – The Trust was found to be compliant and the inspectors were told about the medical and midwifery staffing arrangements. Senior staff said that there were sufficient midwives available on the maternity wards and in the Community to support women in the County. What was not made clear was whether or not there were sufficient midwives to provide 1 to 1 care for women in labour and this will be an area to be examined by the Reviewers.
Outcome 14: Supporting Workers – The Trust was non-compliant however the staff the inspectors spoke to on the maternity ward said they received good support from their seniors and managers.
Outcome 16: Assessing and monitoring the quality of service provision – The Trust was found to be non-compliant. The report on the maternity outliers alert *'highlighted concerns regarding the puerperal sepsis and other puerperal infections'* and that there were issues around clinical coding. The Maternity Risk Strategy was reviewed and the Specialist

Midwife for Quality and Safety confirmed that risks were reported on a monthly basis. In the light of this issue, and that sepsis has been flagged up as a major cause of maternal deaths in the latest CMACE Report (2011), the Reviewers will examine arrangements for maternity outliers and sepsis during the review process.
Outcome 17: Complaints – The Trust was found to be compliant.
Outcome 20: Records – The Trust was found to be compliant.
Although the CQC Report has been considered, neither the Trust Action Plan nor the results of the CQC follow-up were available to the Reviewer at the time of reporting.

7.8 Summary

There have been numerous reviews of the Trust, particularly over the past 9 months, and both Clinical Reviewers have concerns about the possible negative effects on the service's morale and stability that another review may have.
The information in the documents reviewed does not clearly quantify specific clinical issues but in general the service was not found to be wanting to any significant degree.

There are areas mentioned in documents 1,3,4,5, and 7 which will be particularly examined during Phase Two of the review process which will include:

- Recent satisfaction surveys
- Midwife to births ratio
- Perinatal mortality
- Maternity escalation policy
- Perinatal mortality and morbidity multidisciplinary meetings
- Perineal trauma
- Maternal blood loss
- CTG classification and interpretation
- Management of medicines
- Bed capacity.

8. PHASE TWO

To review clinical policies and care pathways

This desktop exercise was undertaken jointly by the Midwifery and Obstetric Reviewers and was completed on the 1st December 2012.

8.1 Clinical policies and pathways

The Clinical Reviewers requested copies of all the clinical guidelines and policies relating to maternity care and these were very helpfully supplied in two indexed folders each containing 31 documents. The Reviewers worked together through the 62 documents noting when each document was written, when it was last reviewed and amended, checking references to appropriate guidelines and identifying documents which needed reviewing or updating.

The Reviewers found that the documents were in a standard Trust format, well written, easy to follow and that the majority were appropriately and well referenced and the reviews were up to date. The Reviewers were not aware of any omissions relating to maternity care. Of particular note was the policy for Transfer of Activity and Closure which comes into operation during periods when there are short term staffing and/or capacity problems.

Because of the size of the documents (some were in excess of 50 pages) it was not possible to examine each document in detail but the Midwifery Reviewer did examined 10 documents (16%) and found them to be in accordance with available national guidance.

In the Phase One Report of the Review the Reviewers indicated that they would examine the management of medicines in the light of the CQC Report. Unfortunately the Trust policy for the storage and administration of medicines was not contained in the file but the Reviewers will examine the policy during their on-site visits.

Of the 62 documents reviewed 11 were past their review date, 4 of which needed current references. (See below)

Guideline/policy	Last Reviewed	Up-date Reference
Female Genital Mutilation	2011	
Patient Identification Policy	2010	
Management of Breech Presentation	2011	Needed - RCOG
Waterbirth	2004	Needed – WHO
Epidural Analgesia	2007	
Admission to NNU over 34 weeks gestation	2009	
Management of Neonatal Jaundice	2012	NICE guideline
Management of Erb's Palsy	2009	
Examination of a Stillbirth/Fetal Loss	2011	
Management of a Maternal Death	2010	
Reduced Fetal Movement	2011	Needed - RCOG

A recommendation will be made regarding the updating of documents in the Final Report.

8.2 Serious Untoward Incidents (SUI)

The Clinical Reviewers requested the SUI Investigation Reports from 2009 to Sept 2012 along with the Terms of Reference for the Perinatal Mortality Review Panel and minutes of the Panel Meetings.
There were 21 SUI Reports contained in the file supplied. Each report was in a standard format and indicated thorough investigation, a root cause analysis, identification of problems in care, lessons learned and an action plan.
The Midwifery Reviewer examined in detail 9 (42% of total) cases, in sequence in the file provided, which had a Divisional Deadline Date in 2011. In each case a Root Cause Analysis (RCA) was undertaken, there were lessons learned and recommendations were made and, as far as it was possible to determine without examining medical records, the cases were appropriately categorised and thoroughly investigated. Where there were problems in care the action plans appeared reasonable. Of the 9 cases with a deadline date in 2012: none were Never Events, 1 was downgraded to moderate, 2 had no avoidable factors, and 1 was a woman who committed suicide while under psychiatric care. The remaining 5 cases had care problems for which remedial action was required and it was interesting to note that 'capacity', i.e. no bed available, was a factor in 2 cases and poor CTG classification and/or interpretation was a factor in 3 cases.

Having reviewed the minutes of the Perinatal Mortality Meetings and the minutes of the Perinatal Risk Group the Midwifery Reviewer is of the opinion that all reported incidents, serious and moderate, were dealt with appropriately. All cases requiring follow up action remained on the meeting agendas until appropriate action had been confirmed.
Staffing issues and capacity issues are continually reported to the Perinatal Risk Group and in most months they are in the highest five reported incidents. Poor CTG classification and interpretation are also frequently reported. This is a problem common to most maternity units and UHL are continually updating midwifery and medical staff with master classes available.
In order to benchmark the Trust with regard to SUI the Midwifery Reviewer obtained information relating to SUI in the West Midland and Midlands and East via the Local Supervising Authority (LSA). There is a significant difference in the number of SUI reported across the Cluster. This is partially attributed to the SHA classification which changed in July 2012 and in subsequent years comparison will be more meaningful. There were also significant reporting differences within the West Midlands e.g. in the year 2011/12 one trust reported 62 SUI and another trust, with a similar delivery rate, only reported 3 SUI. For this reason it was considered unsafe to benchmark but sufficient to say that UHL with 13 reported SUI had less cases than 11 trusts in the West Midlands.

8.3 Perinatal Mortality

The Trust recognised 3 years ago that they appeared to have high levels of perinatal mortality. Since that time the Trust has been working with Public Health and a local Professor of Epidemiology to review the data. Data collection and review has continued and the rate has fallen to a reassuring level of 7.9 unadjusted and 4.7 adjusted i.e. excluding terminations of pregnancy, lethal congenital abnormalities, less that 22 weeks gestation and less than a birth weight of 500g.The process of monitoring and analysis has continued through the Perinatal Mortality Group.

8.4 Governance, management and clinical leadership structures

Clinical governance is the system by which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and there are three key components that contribute to the governance system i.e. clinical effectiveness, risk management and patient focused public involvement.

At UHL clinical effectiveness is measured through a number of channels. There is an appointed Clinical Governance Manager for women's services, a Quality and Safety Co-ordinator and a Specialist Midwife for Quality and Safety. All work together within the Policy and Guideline Committee, the Perinatal Review Panel and the Perinatal Risk Group to monitor outcomes, review and update policies and guidelines to reflect current national guidelines and best practice. This collaborative work is indicative of an organisation working continuously to improve quality and safety.

The Maternity Dashboard is a system of reporting outcomes where individual trusts set their own criteria and targets. UHL have set high standards and as a consequence the Dashboard shows frequent red ratings. This, however, should encourage Commissioners as it demonstrates that within the Maternity Service there is a concerted effort to raise standards of care.

Although the National recommendation for the Midwife to Births Ratio is 1:28 the local agreement was to set a target of 1:32. Only midwives in a clinical role are included in the calculation i.e. it does not include midwives whose role is purely management or in specialist roles e.g. Risk Management, Public Heath or Education. The ratio set by the Trust relates to the funded establishment whereas the actual ratio varies and is adversely affected by sickness absence, maternity leave and vacancies. Given that staffing is a recurrent problem reported to the Perinatal Risk Group and the Delivery Suite Forum the Reviewers are of the opinion that the local target should be 1:28 and that this ratio should be according to Birth Rate Plus calculations i.e. 21% built in to compensate for sickness absence, maternity leave, training, education and statutory Supervision of Midwives.

The Obstetric Reviewer examined the Dashboard and compared it with his own unit and noted that the reporting of postpartum haemorrhage (PPH) is more stringently reported at UHL and that 3rd and 4th degree

tears are reported as a percentage of total deliveries rather than split between normal births and instrumental deliveries which would be more meaningful. Following communication with a Dashboard expert, consideration should be given to having a separate Dashboard for each of the two Consultant Units and the Reviewers will make recommendations in the Final Report.

The Reviewers are of the opinion that, within the Maternity Service, there is a multidisciplinary approach to risk management which is sound.

UHL uses the Meridian Desktop electronic system to record patient satisfaction with the service following childbirth. The system is being adapted and modified to accommodate women unfamiliar with technology and those whose first language is not English. The results from November 2011 to October 2012 were reviewed. 82 responses were collated and 44 (53.66%) rated the service as Excellent, 24 (29.27%) Good, 2 (2.44%) Fair and only 1 (1.22%) rated the service as Poor. There is a RAG rated set of 26 questions relating to antenatal care, labour and birth, postnatal care and overall care which give the Trust a snapshot of areas that need improvement. Two of the clusters of red related to patients' not fully understanding answers to important questions that they had asked staff. This system of collecting information relating to the patients experience is efficient and automation means that data can be presented easily and graphically. As the Trust has around 11,000 deliveries a year, the responses in 2011/12 only gives the views of 0.74% of women and efforts should be made to help and encourage more women to use the system.

The Clinical Reviewers have considered both the Divisional Structure for Women's and Children's Services and the Women's Services Clinical Business Unit (CBU) Structure and, while it is difficult to see how the structures work as a desk top exercise, there appears to be a strong and appropriate clinical leadership structure. Both Reviewers agree that there appears to be an anomaly i.e. the CBU Head of Midwifery (HOM)/Lead Nurse, with overall professional responsibility for nurses and midwives in the CBU covering three sites and the Community is also, at the next level down on the structure, identified as Service Manager for Maternity with the additional responsibility as a Supervisor of Midwives. This appears to be an inordinate workload for one person and would warrant the appointment of a separate Service Manager to work under the direction of the HOM/Lead Nurse.

8.5 Summary

Risk recognition and reporting mechanisms are good and actions relating to audit, staff training, policies and system adjustments are timely and effective.

The weaknesses in both quality and safety still remain to be those of staffing and capacity. Until a long term solution regarding capacity and the increase in the funded establishment of midwives is agreed the quality and safety weaknesses will remain.

Medical cover of the maternity units was not considered in Phase Two but will be examined during Phase Three.

There is a multidisciplinary approach to risk management which is sound.

There is an effective reporting tool to capture the patients experience and satisfaction with the service which needs to be expanded to capture the views of a greater number of women.

The Divisional Structure for Women's and Children's Services appears to be satisfactory with appropriate clinical leadership. However within the Women's Services CBU Structure an anomaly appears to be the inordinate responsibility for the Head of Midwifery/Lead Nurse of the CBU who is also Service Manager for Maternity and has the additional responsibility as a Supervisor of Midwives.

9. PHASE THREE

To undertake site visits and staff interviews.

9.1 Site visits

The Midwifery Reviewer was on-site for 8 days between the 19th and 30th November and the Obstetric Reviewer for 5 days from the 26th to the 30th November when all areas where maternity care is provided was visited on all 3 sites by both of the Reviewers. During that period the Midwifery Reviewer, over both sites, conducted 37 one-to-one interviews, held 2 open staff meetings and 4 group meetings attended in total by 54 staff. In addition the Reviewer talked on an informal basis to 20 patients on the wards and in clinics and sat in on the CBU Quality and Performance Board Meeting. The Obstetric Reviewer had 20 one to one meetings with medical staff and managers.

Both antenatal clinics in the LRI and LGH were bright, welcoming and appeared very well organised with adequate facilities for specialist investigation and counselling. The Midwifery Reviewer talked to 9 women in clinics at RRI and 5 women at an LGH clinic. There were a mixture of first time mothers and those who were having their second or subsequent babies. None had major complaints about the service. One woman said that she had been in the clinic over 2 hours but in that time she had been scanned, had a Glucose Tolerance Test (GTT), further blood test and was about to see a Consultant. One woman said that when she had her last baby at LRI her induction had been delayed, that the unit was very busy but that once she had delivered the midwives were 'really supportive'.

The wards providing antenatal and postnatal care on both sites were very busy and at times had no beds available. The women who talked to the Midwifery Reviewer however seemed happy with their care and there was a camaraderie among staff who were rising to the challenges of the day.

Both delivery suites were also very busy and the Midwifery Reviewer noted that there were occasions when women were delivered in the Midwifery Assessment Centres (MAC) because of a shortage of delivery rooms. Because of the high workload women who were assessed as 'low risk' rarely received 1 to 1 care in labour which is recommended in Towards Safer Childbirth (Ref.1:2003).

The Trust's aim is to provide a ratio of midwives to women of 1:32 and the number of midwives in the service at the moment is clearly not sufficient to provide quality care for women. (See phase 2 Report) The Birthrate Plus Acuity tool used on both delivery suites clearly show major daily deficits and the situation will not improve until there are sufficient midwives working clinically to provide not only a safe service but also a quality service. (Appendix 2.)

Because there are times when postnatal beds are not available women are frequently transferred home straight from the delivery suites on both sites and sometimes during the hours of darkness. This is not necessarily unsafe but it is not quality care.

The maternity service was originally designed to accommodate 8,000 deliveries yet the number of deliveries for 2012 will be around 11,000 and therefore it is not surprising that there is a chronic shortage of beds,

coupled with the fact that in 2004 the Trust decommissioned a whole ward (ward 3) at LRI to facilitate the Neonatal Unit with the loss of 26 beds. The following year there was an increase of 4 beds at LGH but this still left the service with a deficit of 22 beds.
Both Reviewers looked at the plans for the Interim Solution with building work due to begin in January. This will provide improved facilities, will help to streamline the service and will redress the balance of the loss of beds somewhat with an additional 2 delivery beds and 12 inpatient beds at LRI and an additional 2 delivery beds at LGH. This is still 4 beds short of the total beds in 2004 when the birth rate in Leicestershire was 9,623 and 1,500 fewer than expected for 2012.
It was disappointing to note that waterbirths, now considered to be an integral part of normal midwifery care, (Ref.2:2006) are currently not available to women at LRI because the birthing pool is awaiting repair or replacement.

9.2 Early Pregnancy Assessment Unit (EPAU)

Both Reviewers visited the EPEU separately and unannounced during the site visits.
The Unit is self-contained in the Jarvis Building at the LRI, separate from the gynaecological wards and departments of the maternity unit and offers a service Monday to Friday 08.30 hrs to 17.00hrs. In addition sessions are run in the Kensington Building on Saturday and Sunday mornings provided a sonographer is available.
Women can be referred from a number of points i.e. GP Surgery, Community Midwife, Urgent Care Centres, A&E Department and Antenatal Clinics. Criteria for referral is strictly between 6 and 16 weeks gestation by appointment and women who receive bad news are counselled by experience nurses working in the EPAU and referred on for appropriate treatment and care.
The service runs well and the throughput is approximately 140 women a week. No problems were reported except that there are sometimes inappropriate referrals from GPs i.e. before 6 weeks gestation but staff do feedback to the surgeries when this happens.
The Reviewers have no concerns or recommendations about this service.

9.3 Neonatal services

There are 2 units which care for pre-term and sick neonates. The unit at LGH is classified as a Level 1 Unit (Special Care Unit i.e. SCBU) and is only designed to care for babies not requiring ventilatory support. The capacity is 12 cots but in the last 12 months there were 113 days where capacity was exceeded.
The unit at LRI, which was visited by the Obstetric Reviewer, is classified as a Level 3 Unit (NICU) and is able to provide a full range of care from Special to Intensive care. The unit does not provide for babies who need ECMO (circulatory assistance to by-pass the lungs) but this treatment is currently available at the Glenfield Hospital. The NICU provides 10 Intensive care, 8 high dependency and 10 special care cots with a total

capacity of 28 cots. In the last 12 months there were 30 days where capacity was exceeded.
It is not uncommon for neonatal units to exceed capacity or close to admissions but there is a national neonatal network and transport system which is used to facilitate transfer of care.
The Obstetric Reviewer was very impressed with the NICU and the organisation of care and the Reviewers have no concerns or recommendations regarding this service.

9.4 St Mary's Birthing Unit

The Midwifery Reviewer spent one morning visiting St Mary's Birthing Unit in Melton Mowbray which is a facility for low risk women to deliver their babies in a homely environment cared for by midwives and support staff. The unit is staffed 24/7 and in addition to birthing rooms there is an 8 bedded postnatal ward. There is no provision for medical back-up by local GPs or from the Consultant Units and therefore the clinical provision is the same as for homebirths.
The concept of midwifery led care for low risk women in a Freestanding Birthing Unit (FBU) is good and has been supported by the recently published Birthplace Study (Ref.3:NPEU 2012) which reports **'For women having a second or subsequent baby**, **home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother'**. However the unit in Melton Mowbray do not restrict their services to multiparous women (having second or subsequent baby) and the same report goes on to say **'For women having a first baby, a planned home birth** (*the same provision as offered at St Mary's)* **increases the risk for the baby'**. And: **'For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after birth.'** The transfer rate quoted in the study for women having their first baby was between 36 and 45%.
The building at St Mary's is old and in need of renovation and redecoration and the service so underused to be unsustainable. In the 11 months of 2012 there were only 207 deliveries which is an average of 4.3 deliveries a week. In the same period there were 38 women transferred to a Consultant Unit in labour, half of them in the 2nd stage.
The problem with sustainability relates in the main to the location of the Birthing Unit which is rural, 17 miles away from medical assistance and a journey of approximately 40 minutes on mainly single carriageway roads. When a clinical emergency occurs with a mother, e.g. PPH, the midwives are not trained to canulate and give I.V. fluids and if a baby fails to establish respiration the midwives are not trained to carry out advanced resuscitation of the newborn. In an emergency midwives are totally reliant on the East Midlands Ambulance Service to provide paramedic assistance and transfer to hospital.
On the day the Reviewer visited there were 5 of the 8 postnatal beds empty and the 3 women in-patients were not receiving any care or support which could not have been provided in their own homes by the Community Midwifery Team.

The 2 birthing rooms were occupied with labouring women during the Reviewers visit and it was interesting to note that both were later transferred to a Consultant Unit, one in the 2nd stage of labour.
There are no clinical services provided at St Mary's (which were described to the Reviewer as the same provision as for a home birth) which cannot be provided by the Community Midwives in the homes of women living in the Melton Mowbray area.
The closure of this unit would provide additional staffing for the Consultant Units, the women who were eligible to use the unit could equally choose to have a homebirth and those who did not choose to have a homebirth could be accommodated in one of the Consultant Units.

9.5 Obstetric Good Practice

There were no observed or identified issues of obstetric practice or practitioners that would suggest that the department is currently offering anything other than a good quality service supported by a bedrock of excellent midwifery care, especially considering the difficult and demanding demography of Leicester City and current insufficient capacity to provide the service within the Trust.

Of particular note were:

1. Consultants at the LRI working in tandem on the labour ward during the morning sessions and in antenatal clinics, offering a consultant based (rather than consultant led) service.
2. The midwife-led Pregnancy Assessment Service at the LGH is an effective antenatal outpatient service with telephone access for consultant opinion and advice that reduces antenatal admissions.
3. An excellent communication system for discussing and planning care for women with complex antenatal problems with the neonatology and obstetric anaesthetic departments.
4. Tertiary referral fetal medicine service despite recent reduction in number of consultants because of maternity leave.
5. The department's network of administrative Leads is well structured and there are robust Trust and departmental clinical audit and risk management systems.

9.6 Obstetric Risk

1. Most, if not all, the risk stems from the current structure and capacity of the medical staffing to cover both the obstetric and gynaecological services on two campuses. These systems are put under maximum strain at times of staff changes, popular annual leave periods and peak maternity activity, in particular, during August and September each year. There is no slack in the system for daytime prospective cover of the labour ward and other duties by consultants on both campuses.
2. There is a lack of secretarial support for the obstetric staff at the LRI and unsatisfactory cramped working conditions. The two secretaries (one part time) appear to work very efficiently and effectively, even organising

consultant labour ward daytime cover for the weekly rota. The individuals concerned are highly valued by all the consultants but, if one were to be absent for any length of time, the organisation of the department could suffer and create clinical risk.
3. Poor patient pathway flows currently being experienced pose risks to the department and Trust in the form of patient dissatisfaction, complaints and a loss of reputation within the local community.
4. The longer term risk for the department is that this stopgap Interim Solution, by default, becomes the final plan with no future development of the Leicestershire Maternity Services.

9.7 Midwifery good practice

1. Management

The Trust have strengthened its midwifery management fairly recently by the appointment of 4 senior managers (Band 8). These managers are responsible for Inpatient Services (one on each site), Community and Quality Standards & Public Health. These new managers, along with the rest of the Management Team are very visible in the clinical areas and many staff commented in interview how much their support was appreciated.

2. Birthrate Plu**s**

The Trust has invested in the Birthrate Plus Intrapartum Acuity Tool which has been in use since August 2011. The purpose of the tool is to collect data relating to not only the number of women on the delivery suites but also the complexity of the care needed and the appropriate available staff. The tool requires the coordinators on each shift to complete a data form for every 4 hour period. The results are translated into a weekly report with the following colour rating: GREEN = meets acuity, YELLOW = up to 1 midwife (m/w) short, ORANGE = up to 2 m/w short and RED = more than 2 m/w short. This tool gives the Trust a very clear and on-going picture of shortfalls in the number of midwives needed to provide care to women. The Midwifery Reviewer examined data for 1 week from 4 separate months from both sites. Even on the best staffed week LRI showed 69% and LGH 40% of the time they were more than 2 m/w short with minus 6 for 9 periods at LRI and minus 6 for 3 periods at LGH. On the worst week LRI showed that 98% and LGH 73% of the time were more than 2 m/w short with 26 periods at LRI and 9 periods at LGH when they were more than minus 6 m/w short. The greatest deficiency at LRI was minus 12.35 and minus 8.7 at LGH. This tool strengthens the way the Trust identifies staffing needs and is good practice because it highlights the daily risks associated with suboptimal staffing in a critical care area and identifies the need for improvement.

3. Education

The Midwifery Reviewer met with 3 members of the Education Team who organise and facilitate on-site training for staff working within the Division. All newly qualified midwives are provided with a formal period of preceptorship which normally lasts a year. During this period they are trained and assessed in various clinical skills including perineal repair, oral and I.V. drug administration, epidural top-up and I.V. canulation. The Team facilitate Parent Education training for Community Midwives, NVQ training for maternity support workers (MSW), Advanced Life Support in Obstetrics (ALSO) and Managing Obstetric Emergencies and Trauma (MOET). The Midwifery Reviewer was very impressed by the organisation of Multidisciplinary Obstetric Training (MOT) provided annually for all medical and midwifery staff. The Team run 13 sessions throughout the year which as well as improving clinical skills has greatly improved working relationships between staff. Funding for degree and top-up courses is good.

4. Staff selection

The Midwifery Reviewer was impressed to learn that there is a stringent selection process for the recruitment and appointment of midwives. Following the initial selection of appropriately qualified midwives, each applicant must sit a short written test to assess their knowledge regarding particular areas of clinical practice which, in the previous week, included classification and identification of a CTG trace and on this occasion 2 applicants were excluded from interview because of badly answered questions. When Trusts are very keen to fill vacancies it is easy to recruit all registered and qualified applicants and the Trust are to be commended for their wisdom in this additional screening.

5. Patient Feedback

The Trust uses an electronic system to survey the patient experience but the Midwifery Reviewer observed 2 different comment cards in patient areas on the wards which will provide additional feedback. U Help Us Learn encourages patients to write comments on a card with the option of identifying themselves if they wish. There is also a more detailed card: Message to Matron, which asks ‘What we did well?’ ‘Make a suggestion for improvement’ and ‘Thank a member of our team’.

6. Addressing risk factors associated mortality and morbidity

The Trust has worked hard in providing information and specialist midwives to support pregnant women who are HIV+, teenagers, diabetic, have hypertension and renal diseases, who are drug abusers, in vulnerable groups or where there are safeguarding issues (Ref.4:2010) . There is also an Infant Feeding Specialist to support all mothers but to particularly promote the health benefits of breastfeeding. Smoking cessation in pregnant women is high on the Government agenda and all

Community Midwives discuss the issue at booking and the Consultant Midwife in Public Health audits discussions and referrals for help and report to the CQIN Group. (Ref.5:2010)
It was encouraging to note the improvement in breastfeeding rates. Leicester City exceeded national targets for 2011-12 at 54%. This is higher than the rate for both County and Rutland and the Average for England.
The teenage conception rate has reduced by 31% from 1998 to 2010 which exceed the national target of 10% per year. Leicester City still has significantly higher rates compared to the national average whilst the County and Rutland have significantly lower rates than the national average.
The Trust also supply information regarding 'safe sleeping' and minimising the risk of cot death.
In the light of the last 2 reports of Confidential Enquiries into Maternal Deaths (Ref.6:2007 & 2011) which highlighted suicide as a significant cause of maternal death, it would be appropriate to appoint an additional specialist midwife for mental health.

7. Maternity Support Workers (MSW)

The introduction of 9.4 whole time equivalent (WTE) maternity support workers to work alongside community midwives in the City is a quality initiative which has improved services and support to the most vulnerable of women. Their role includes:

- Performing pregnancy tests
- Providing breastfeeding support
- Smoking cessation intervention
- Performing Chlamydia tests
- Providing parent education sessions
- Performing newborn screening tests
- Supporting postnatal mothers & their babies between midwife visits
- Helping to arrange interpreters when required
- Chasing up women who do not attend appointments

This initiative contributes significantly to improving breastfeeding rates and reducing the risks of health inequalities.

9.8 Midwifery risk

1. Staffing and capacity

Staffing and capacity remain the top 2 highest risks on the Trust Risk Register and will remain so until there is an increase in the numbers of midwives working clinically and an increased bed capacity which will be addressed when the Interim Solution is fully implemented.
This year the Midlands and East SHA have reviewed the staffing of all maternity services in a Birth Rate Plus Table Top Exercise. The exercise confirmed that UHL needed a midwife to births ratio of 1:28. 21% is built into this calculation for sickness absence, maternity leave, training, education and statutory Supervision of Midwives.

During staff interviews the workload was described as being 'relentless', and the workplace as being 'like a war zone' 'fire fighting all the time'
The services which are hospital based are stretched to the limits because of increased activity and dependency and there is an overall need for more midwives, support staff, medical staff and beds. The Reviewers have formed the opinion that the service is safe for most of the time but that the quality of care is often poor during the frequent busy times.
The Trust actively manages the continuous risk by regularly calling in Community Midwives who are on-call and activating the policy for Transfer of Activity. This means closing one unit and transferring activity to the other unit which in turn puts the receiving unit under increasing pressure. There is a see-saw effect and often the units can be closed to admissions 6 times in a month. This action ensures safety for women but it certainly is not quality care. Because the Trust is responsible for both sites it is very rare that it has to close completely with the consequential transfer of activity out of the County to another Trust.

2. Sickness absence

The Trust scrupulously monitors and actively manages sickness on a monthly basis. The Trust overall target rate is 3% and the Women's CBU target is 3.5%.
Long term problems with staffing and capacity, particularly in critical care areas like delivery suites, are very likely to result in high sickness absence rate.
The Trust figures for the 13 month period from April 2011 to the end of April 2012 show that the rate for the whole of the Women's and Perinatal services was within the target at 3.4% but unsurprisingly the Delivery Suite at LGH and Obstetric Ward 5 were above 4.5% and the Community Midwifery (70 staff) were above 5%.
This high sickness absence rate compounds and increases the risks associated with suboptimal staffing.

9.9 Supervision of Midwives

The role of Supervisor of Midwives (SOM) is statutory. The requirement for the provision of SOM is obligatory and the purpose of the role is to protect the public (mothers & babies), to monitor standards of care, support midwifery practice and in doing so is an excellent risk management tool. The responsibility for the selection, training and subsequent appointment of SOM lies with the Local Supervising Authority (LSA) Midwifery Officer(MO) who, for the East Midlands Area, is based in Nottingham.
The standard of Supervision in the Trust is excellent and the midwives generally consider that they are well supported by their personal SOM who they meet on a regular basis.
The Midwifery Reviewer had a telephone meeting with the LSAMO to ascertain her opinion about the safety and quality of the maternity service provided by the Trust. Her overall comment was that there has been a year on year improvement in the standard of care despite the increasing

complexity and complications in pregnancy for many women and her detailed annual report was published in on 28th June 2012. (Ref:7 2012/13)
The Nursing and Midwifery Council (Ref: 8 2004) recommend a ratio of no more than 1:15 SOM to midwives and at this present time the ratio is 1:20. Each SOM is required by the NMC to carry out the minimum of an annual review with each of her 20 supervisees which places an additional burden on those midwives who are also SOM. The training and appointment of more SOM would reduce the burden on the current SOM and improve the general standard of Supervision.

9.10 Complaints management

The Trust has an active system of complaints management headed up by the Quality & Safety Manager. The Trust collate verbal and written complains which can be sent directly from patients or via staff, GPs or the PCT.
The Reviewer asked for details of complaints relating to the Maternity Service during the last 6 months (May to October). There were 96 complaints during this period which is an increase of 20 for the same period in 2011 and there was a particularly high peak in August which has historically been one of the quieter months for complaints. There did not appear to be to be a specific trend or theme and some of the complaints referred as far back as 2007 which may be as a result of negative media coverage mid-2012.
The number and themes of complaints received for the whole of the Women's and Children's Division are reported to and monitored on a weekly basis. In addition a monthly report is submitted to the Maternity Services Governance Group, the Women's CBU Board and the Divisional Board. The aim is to identify any trends or themes at the earliest opportunity. All complaints have an action formulated to ensure key issues are addressed.
Over the last 2 years the Division has introduced a number of initiatives to inform the Trust of patients concerns and improve the patient experiences which include:

- The introduction of communication and complaints training for all staff within the Division.
- Midwife in Charge/Matron badges in order that patients and their relatives can easily identify key individuals.
- Hourly nursing rounds to ensure there is a regular point of contact with patients and that there needs are assessed.
- 'U Help us Learn' and 'Message to Matron' cards introduced to improve communication and patient experience feedback.

The Midwifery Reviewer examined the last 62 complaints received by the Trust and although many related to clinical care often issues were to do with high activity and the lack of beds.
It was interesting to note that there were no complaints about maternity services escalated to the Parliamentary and Health Service Ombudsman

in the past year and this may be because of effective complaints management.

9.11 Open staff group meetings

When a service is under a Review staff can often feel under pressure to be seen to be performing well and need reassurances to enable them to contribute meaningfully to the review process. In order to explain the process, emphasise the independence of the Reviewers and confirm confidentiality midwifery staff (midwives and support staff) were invited to open meetings on both sites. To encourage frank discussion managers were excluded from these meetings and the Midwifery Reviewer began each meeting with a personal introduction and an assurance that all the questionnaires completed during the 1 to 1 interviews belonged to the Reviewer and, although the information gained during interviews may be used in the Final Report, the Reviewers would not identify the individuals who shared the information. In addition to the 2 major meetings the Midwifery Reviewer also had group meetings with Supervisors of Midwives and the Education Team.

The 2 Staff Meetings were relatively well attended given that both units were busy. The meeting at the LRI had 16 attendees (13 midwives and 3 support staff) and the meeting at the LGH had 8 attendees (6 midwives and 2 support staff). It was obvious at the outset of both meetings that staff were concerned about the Review and many were unsure about the process and why they were being called for an interview but by the end of the meetings many said they felt more comfortable and there was a general agreement to cooperate.

There was much discussion about quality and safety issues. Unsurprisingly the 2 top concerns were about staffing levels and the lack of beds and that the staffing problem compounded the bed problem as there was often a backlog of newly delivered women waiting for their paperwork to be completed or for a doctor to do a discharge examination. 2 Midwives concurred that the reduction in Parent Education sessions had impacted on the service with an increase in telephone enquiries for information and minor issues and an increased attendance in MAU.

At the LGH meeting there were complaints about delays in clinics caused by consultant clinics being cancelled. (***The Midwifery Reviewer passed this information to the Obstetric Reviewer to follow up)*** Some staff did not like the new long shifts and said they frequently went long periods without a break and others said that they were disappointed that the Trust did not feed back to them following staff surveys.

9.12 Interviews by Obstetric Reviewer

The list of members of staff who were interviewed by the Obstetric Reviewer can be found at Appendix 4.

All interviews were held in private, comfortable accommodation provided by the Trust with a very well organised timetable over the week of the site visits held from 26th to 30th November 2012. There was adequate time

with each interviewee, all of whom attended promptly and answered questions openly without interruption. The staff attitudes were very positive about the review and the Reviewer found everyone to be very welcoming.
It soon became apparent that in recent times there had been a lot of time and effort expended by the Women's CBU leadership and others on developing and effecting plans for an 'Interim Solution' to help solve the current problems of the unification of the two hospital campuses under one UHL banner and re-organisation of the Trust's estate, its efficient use and by altering patient care pathways. All this is on a background of a long history of planning and re-organisation of Leicester's Maternity Service, notably including the collapse of the Pathway Project which was to see a new maternity hospital on the Glenfield Hospital site. The Interim Solution contains significant changes to the UHL's gynaecology services including elective surgery, emergency gynaecology and the Early Pregnancy Assessment Unit (EPAU) and although this review is concerned with maternity services, these changes have had a significant impact on consultant job plans and training opportunities, as many of the consultant staff and most of the trainees practise both obstetrics and gynaecology. In addition, there are six peripheral hospitals, five of which offer consultant-based gynaecological services and consequently take consultants off UHL campuses on four days each week (M,T,T,F) and so they are unavailable for cover at UHL for obstetric sessions on those days.

There were several recurring themes from the interviews, enquiries and observations during the visit.

9.13 Leadership

The Women's CBU leadership have been completely occupied by the development and execution of the Interim Solution which has also included the difficulties in melding the two cultures from the two hospitals in the UHL. This appears to be at the expense of the day-to-day operational activities of the now, unified department. The pressure on the leadership has been increased because the post of Head of Service (HoS) for Gynaecology is vacant and the Head of Midwifery is also acting as service manager for Maternity. There are no longer any regular consultant meetings with the leadership to discuss general issues other than the Interim Solution where "decisions are made in closed rooms" and "more transparency" is needed. Many of those interviewed complained that "no-one is listening" and so there is a disconnection between the leading team and the consultant body. This notion was confirmed by those from outside the department (obstetric anaesthetists and neonatologist) who also stated that were "poor communications" within the department. Everyone is working extremely hard and "love their job" despite the long hours but a co-ordinated approach to problem solving is lacking at present in the department.
While Trust annual Consultant Appraisal is effective with five trained appraisers, consultant job planning does not occur annually and seems to

occur on a 'need to do' basis rather than a co-ordinated planned annual event. There does not appear to be enough time or support for the leadership e.g. job plan with only 1PA, 4 hours a week, dedicated for the HoS work, amid their heavy clinical workloads, and this includes inadequate daytime support from the junior medical staff, but also, the HoS has other non-clinical commitments outside the department e.g. job plan with 2PAs (8 hours/week) for work in the Medical School.
A lot of the departmental communications occur by e-mails or on an individual face-to-face basis in a 'top down', rather than in a more consensus-type, open forum. The leadership need "greater visibility". The leaders, on the other hand, feel beleaguered with little or no scope for innovation, research and future development, while any change is not only difficult to manage, it is slow to be realised.
There appears to be resistance to the formation of new team structures to manage common patient care pathways across the two campuses. More support from the Trust's Divisional Director for Women's & Children's Services is necessary to facilitate cross-site working and to support the Trust's mantra of 'Two sites, one Trust'. However, the department's network of administrative Leads is well structured and there is a lot of individual enthusiasm for these roles and represents one of the departments strengths, but again the time given in Supporting Personal Activities (SPAs) in job plans was mostly inadequate, usually only 0.5SPA (2 hours/week). Most, if not all the consultants, do this managerial work out of hours even though most are contracted to do 11 or 12 PA in their agreed job plans, which is in excess of the standard full-time Consultant Contract of 10PAs and probable reflects poor planning. There were no concerns about any of the consultants in terms of their professionalism, capability and performance as competent practising obstetricians (and gynaecologists) or to their individual commitments to their department and specialty.

9.14 Staffing levels

There are five locum consultants currently working in and for the department, four of whom are employed as obstetricians in the Maternity Service (some with gynaecology sessions too): two are employed to cover maternity leave; and two for retirements. One of the locums contributes to departmental management as Audit Lead for the LRI campus. It remains unclear what level of clinical activity those returning from maternity leave will take up. This locum situation is less than desirable although the Labour Ward Lead stated that the locums offered flexibility as 'gap fillers'.
At present both labour wards are staffed with consultant presence to 60 hours per week but this is well below the levels recommended by the RCOG (*Safer Childbirth: Minimum standards for the organisation and delivery of care in labour*. RCOG Press, 2007). LRI with 6194 maternities/year should have 168 hours; and LGH with 4260 maternities/year should have 98 hours. The required labour ward staffing levels appear to be maintained throughout the day as a departmental priority but at times at the expense of the duties on the wards or in the outpatient departments. One trainee stated, "There is nobody to do the

wards cover" and consultants often do their ward rounds alone and in between their other clinical commitments. Plans are being developed to address these issues and four options have been appraised (*see: Medical Staff Resources Analysis, Author: Cathy Morgan, Dated: 3/11/2012*) but the long term consultant complement necessary to provide safer childbirth cannot readily be determined until a final plan for the Leicestershire Maternity Services have been developed and agreed, presumably one maternity unit on the LRI site adjacent to the newly built neonatal intensive care unit.

Junior medical staff rotas are under constant pressure because of vacancies, maternity leave and sickness. To organise the daytime clinical duties the doctors are constantly "fire-fighting" and are "pushed from pillar to post" to "plug the gaps" which leads to "disjointed care the way things work" (sic) and "everyday feels a struggle" this all creates great pressures and stress on the rota co-ordinators. The after-hours rotas rely on the "goodwill of the trainees" while the Trust employs a person in the Medical Staff Administration to manage the rotas and has to "coerce and persuade doctors" to do locums "to keep the rotas going". In October and November the department employed locums for the SpR and SHO rotas for 841 hours at a cost of £37,352.50. Moreover, the Medical Staff Administration Manager is very concerned that the situation is reaching crisis point and that the monthly medical workforce meeting with the leadership, that were designed to pre-empt these problems and issues, have fallen into abeyance. This crisis will deepen in August 2013 when the Deanery will no longer employ LATS to fill gaps for such things as maternity leave and out of programme experience. The department has, in part, tried to deal with these problems by creating two Clinical Fellow posts and two posts from the RCOG overseas doctor's scheme.

All these problems adversely affect patient flow through the care pathways and regularly end up blocking beds because of a delay in discharging patients ready to go home, the backlog of which eventually delays discharges from Labour Wards, delaying elective admissions and inductions of labour. Consultants at the LGH site at times have to finish outpatient clinics on their own, leading to delays and increasing patient waiting times. All these episodes cause patient dissatisfaction and increase in complaints. To manage this problem outpatient clinics at the LGH are cancelled (rather than being reduced) when the consultant is unavailable but this disrupts patient appointments and results in larger clinics. This is not such a problem at the LRI where consultants tend to work in tandem in antenatal clinics, which are run on a problem-oriented basis, but is more labour-intensive and probably more costly in terms of consultant job plan PAs. They have also made attempts to manage ward rounds to improve patient flows.

These problems are exacerbated at times of high activity, holidays and when doctors change hospitals in their training programme, making the maternity services vulnerable to risks at these times.

9.15 Training

Training for medical staff is in crisis at UHL. This is evident because in October 2012 a Crisis Meeting was held with the Deanery representatives and college tutors and others to address training issues, notable the inability of the department to deliver on the mandatory Advanced Training Skills Modules (ATSMs) for the SpR6 & 7 advanced trainees. The training at the UHL offers four sub-specialist training posts all of which take up good training opportunities that other trainees need to complete their ATSMs. Labour Ward ATSMs are generally available and not thought to be a problem to provide.

The constant fire-fighting in the day-time rota and the new two site working arrangements have fragmented training and training opportunities. At present the college tutors and trainees are working hard together to help resolve these difficulties.

One of the college tutors is also responsible for Risk Lead at LGH and has only 1SPA for both these two onerous responsibilities in a 12PA job plan; the other has 1SPA in an 11PA job plan and has only just been appointed to that role for the LRI campus although most the clinical activities are located at the other campus. Collectively they are responsible for delivering the UHL training programme to: 17 advanced trainees; 7 middle grade SpRs (+2 clinical research fellows to make up the numbers in the rota); and 17 junior trainees, a mixture of Year 1&2 SpRs, GPVTS trainees and FY1&2 trainees. This combination explains a part of the advanced trainees' ATSM problem; there are perhaps too many of them for the department to provide the mandatory training modules.

9.16 The Interim Solution

The Interim Solution is a stopgap plan to solve some immediate and pressing logistical problems and has four main components: Elective pathways (both in maternity and gynaecology), Fetal medicine; EPAU; and additional beds. There is concern at the LRI that the relocation of the theatres for elective Caesarean section and Maternity Assessment Centre (MAC) downstairs will take medical staff away from labour ward. It is of concern that the Interim Solution lacks a definitive staffing component to deal with these consequent issues that change inevitably brings, together with the apparent medical daytime shortages, in a more planned and co-ordinated way. Other concerns centred on inexperienced junior medical staff attending the MAC to see and assess women with problems in pregnancy. The Lead for Fetal Medicine, who had developed a plan for the future development for the subspecialty on a single site at the LRI campus, thought the plans had been "side-lined" and it remains unclear what reorganisation is planned by the leadership. The nurse-led EPAU in the Jarvis Building seemed to be working effectively and efficiently with access to operating theatres (Kensington Building) from 1000-1200hrs, three days a week for the surgical management of early miscarriage. The changes to the estate on both campuses will be a phased building programme not only to increase the number of beds and their utility, but also to offer women more choice for birthing options, which is to be

applauded. Planning work has begun to develop a final plan so that the Interim Solution does not, by default, end up being the final solution for the Maternity Services in Leicestershire.

9.17 Interviews by Midwifery Reviewer

The questionnaire used in the interviews (Appendix 3) was developed by the Midwifery Reviewer primarily to promote discussion but also to capture relevant information about staff qualifications and experience, support in the workplace, appraisals, Supervision and any concerns about services to women.

Over a five day period the Midwifery Reviewer conducted 35 half hour one to one interviews with midwives: 18 at LRI, 16 at LGH and 1 at St Mary's Birthing Centre.

All were familiar with the Policies and Procedures File on their department and also accessed them regularly on the intranet.

All have had an appraisal during the past year and all but one said it was a positive experience. One midwife described it as 'neutral'

All have had an annual Supervisory Review and all described it as positive. All are being helped with their professional development by either their line manager or SOM or both.

29 Midwives said they enjoyed their work (some said the loved it), 4 said 'most of the time', 1 said 'difficult but good' and 1 said 'enjoy the patient care but hate the paperwork'

When asked if they had any concerns about the service 5 said 'No' (one of whom said 'not at St Mary's or the community'); of the 30 who had concerns all named staffing and capacity (expressed as short of beds) as the main concerns. There were many additional comments which included:

- 'can't always offer appropriate care'
- 'I dread ward 30, its stressful and task oriented'
- 'Service is too busy and getting busier- it's frustrating only to be able to give o.k. care rather than quality'
- 'Too little resources and there's no let-up in the workload – it's like a war zone sometimes'
- 'We just about manage safety but it's tight and the quality suffers'
- 'The service is kept safe by using the escalation policy but the quality's often poor.'
- 'Staffing is dangerous at times.'
- 'Safe but running close to the edge at times and the quality could be better'
- 'It's impossible to give 1 to 1 care for women unless they are having an epidural and synto (Syntocinon)'
- 'Overstretched and constantly frantic so care often just adequate'

When asked if they had any concerns about their working conditions 24 answered 'No' but of them there were 4 negative comments:

- 'No but have a lot of sleepless nights'

- ‘No but Delivery Suite needs a chill-out room’
- ‘No but there’s a relentless workload’
- ‘No but need more hours in the day’

Of the 11 who had concerns all related to workload and included:

- ‘Overworked and understaffed’
- ‘There are tears every day!’
- ‘No breaks in a 12 hour shift’
- ‘No proper breaks and often late off duty’
- ‘Dangerously low staffing particularly on Postnatal Ward’
- ‘No breaks’
- ‘Not enough equipment.’

On the ‘Wish List’ many midwives just wanted more staff but among other things were the following:

- ‘Women to have a better experience’
- ‘To be able to provide 1 to 1 care for all women in labour’
- ‘20 Band 6 midwives!’
- ‘Respect from Band 7’s’
- ‘Have the nice new unit we were promised’

9.18 Follow-up of issues from Phase One which have not already been covered.

1. Maternal blood loss (7.5)

The Reviewers have ascertained that mothers who have had moderate blood loss are followed up appropriately and this will be confirmed by audit report.

2. Management of medicines (7.7 outcome 9)

The Trust has updated the policy on the management and administration of medicines which was reported at the CBU Quality & Standards meeting attended by the Midwifery Reviewer. This issue has now been signed off by the CQC.

3. Puerperal sepsis (7.7 outcome 16)

There has been lengthy correspondence between the Medical Lead Women’s Clinical Business Unit (CBU) and the CQC relating to the reporting of sepsis. The main issue appears to be the coding of pyrexia i.e. one episode of pyrexia was being coded, and thus wrongly reported, as puerperal sepsis. This issue has now been resolved.

9.19 Conclusion

UHL became a Trust as the result of a merger of three separate organisations. The maternity services are now one service on three sites which still has challenges relating to standardising services for women and instilling a sense of cooperate loyalty into staff who have, in the past, been loyal to only one hospital base.

There is a need to strengthen stability, improve support and training and leadership for the medical staff who has been adversely affected by the Trust's focus on managing the Interim Solution and the disproportionate number of locum doctors who, understandably, do not share a corporate loyalty to the Trust.

There is a well-trained and well-motivated team of midwives who feel supported by the new Management Team and there was no evidence of unsafe or substandard midwifery practice. The services which are hospital based are stretched to the limits because of increasing activity and there is a need for more midwives, doctors, support staff and bed capacity.

The Maternity Services in Leicestershire offers a high standard of care but is currently in a state of flux creating challenges that have been, in part, met by the Interim Solution which was developed by the leadership. This process has been demanding on the leadership who now need more SPA time and support from the Trust to re-establish a robust departmental structure to support more changes that are necessary to merge two hospital departments and to reconfigure patient care pathways both in maternity and gynaecology, and ultimately to develop an affordable final plan to consolidate the service. The obstetric service is understaffed and needs more trained specialists and consultant appointments not only to improve consultant presence on the Labour Wards but also to reduce the reliance on trainees to deliver the service and improve the quality of training.

The Reviewers have formed the impression that the service is safe most of the time but the risks associated with suboptimal staffing and a shortage of beds are high and, although they are being actively managed by proactive Supervision, the use of the Birthrate Plus Acuity Tool, the Escalation and Transfer of Activity Policy, often result in poor quality of care during busy periods. The inability to provide one-to-one care in labour compromises safety and the transfer of activity has a negative effect on the birth experiences of women.

Structures and strategies are in place to deliver a first class service however this will not be deliverable until the shortfalls are addressed.

The Interim Solution will improve the bed situation, but even when work is completed the service will have 4 beds less, across both sites, than in 2004. Both Reviewers are concerned that the Interim Solution may become the final solution and all efforts should be made to avoid this happening.

9.20 Recommendations

1. Some of the clinical policies and guidelines need to be reviewed and updated in line with national and good practice guidelines.

2. The Trust should begin to capture data relating to the number of women who deliver outside of the designated delivery areas and particularly in the MAC.

3. The building housing St Mary's Birthing Centre is old and in need of renovation, the service is underused which calls into question its sustainability and therefore it is recommended that further work should be undertaken by the CCGs to look at possible solutions.

4. In order to be able to capture comparable performance on both the LRI and LGH sites develop 2 separate Maternity Dashboards in addition to the existing Trust wide Dashboard.

5. Repair or replace the birthing pool at LRI as a matter of urgency in order to provide waterbirths to low risk women who request them.

6. Develop a structured and effective system of feedback to staff following staff surveys.

7. Explore the possibility of training a team of Maternity Support Workers (MSW) to scrub for Caesarean sections thus relieving midwives of a non-midwifery function.

8. Increase the rotation of Band 6 midwives through ward areas and delivery suites to heighten appreciation of working pressures in both areas.

9. Introduce Examination of the Newborn training for senior midwives on both sites to speed up transfers from hospital to home and to improve continuity and the patient experience.

10. Ensure that plans for a completely new hospital are revisited and that the Interim Solution does not become the Final Solution.

11. Appoint a Specialist Midwife for Mental Health to provide specialist support and help for women with mental health issues thus reducing the risk to both mothers and babies.

12. Appoint a Service Manager for Maternity Services to function under the direction of the HOM.

13. Adjust the funded establishment of midwives to provide a ratio of midwives to women of a maximum of 1:28.

14. Improve the ratio of Supervisors of Midwives to a maximum of 1:15 in accordance with NMC Guidance.

15. Share at least the Executive Summary and Recommendations of this report with medical, midwifery and support staff working within the Maternity Unit.

16. Make consultant appointments to replace the current deficits as a matter of urgency to reduce to department's reliance on locum consultants.

17. Consider other strategies to move the service to a trained specialist based service as recommended by the RCOG (*Tomorrow's Specialist: The future of obstetrics, gynaecology and women's health care*. RCOG. Print Direct. 2012.) employing more consultants and post-CCT fellows (trained specialists) in the short term and reducing the reliance of the service on trainees.

18. Annual job planning, aiming for every consultant to have a 10PA consultant contract but with adequate SPA time for those involved in work as administrative Leads and to rationalise the effective use of consultant PAs by using the excess to contribute to more consultant appointments.

19. Employ three or four post-CCT fellows on a short term basis to support directly the leadership and college tutors with their clinical workload and to bolster the middle grade rota and offer women a more trained specialist service. These appointments should have formal job plans that would be aimed at supporting the appointee's individual professional development, rather than just becoming 'gap fillers'. These short term contracts should continue until such time as the final plan has been determined and the long term consultant complement necessary to provide safer childbirth is established.

20. Appoint to the vacant HoS for Gynaecology as a matter of urgency to facilitate the proposed Interim Solution plans for EPAU, emergency gynaecology and elective surgery and to reduce the burden on the Medical Lead for the Women's Clinical Business Unit. This appointment should also be supported by a specialist trained post-CCT fellow.

21. The leadership should reconvene monthly consultant meetings and medical workforce meeting to discuss departmental issues in a more open and transparent fashion and to be supported more effectively by the Trust's Divisional Director for Women's & Children's Services and/or Medical Director when difficulties are expected or encountered.

22. Ward rounds and MAC assessments should be made by appropriately trained and experienced medical staff on a regular daily basis and

there should be prospective cover available throughout the year for labour ward and elective surgery.

23. The Trust should formulate a plan to increase consultant presence on labour wards to the RCOG recommended levels as soon as possible, as a matter of urgency. The Trust may have to consider disinvesting in SpR training posts to make these changes affordable but this would not be unreasonable as specialty training numbers in O&G are being reduced nationally.

24. Consultant annual leave needs to be better co-ordinated and transparent. Agreed rules about numbers of consultants away at any one time need to be established and adhered to fairly. This is especially important in August and September when the service is vulnerable and at increased risk.

25. College tutors both need the department's support to improve training opportunities and resolve the ATSM crisis. This can be facilitated by reviewing their job plans and dedicating more SPA time and reducing their clinical activity with support from trained specialists.

26. The HoS for Maternity needs more support to manage one of the biggest maternity services in the country. A job plan review is necessary with more SpA time to lead the service and fewer distractions and clinical activities. Consideration should be given to the appointment of a deputy HoS and trained specialist support.

27. The Fetal Medicine reorganisation, as part of the Interim Solution, needs to be agreed on the basis of improving the service for women rather than hospital based preferences and consultant prejudices.

28. The leaders of the Leicestershire Maternity Services should consider establishing a link with those in Nottingham as the two units have very similar structures and have similar problems to confront and a think tank forum to share and discuss these may well prove beneficial for the future.

9.21 References

1. Towards Safer Childbirth. Minimum standards for the organisation of labour wards (2007) RCOG & RCM.

2. Immersion in Water During Labour and Birth (2006) Joint statement RCOG, & RCOG RCM Press.

3. Birthplace Study. Key findings (2012) NPEU Oxford.

4. Pregnancy and Complex Social Factors (2010) NICE.

5. Quitting Smoking in Pregnancy and Following childbirth (2010) NICE.

6. CEMACH (Confidential Enquiry into Maternal & Child Health) (2007 & 2011)

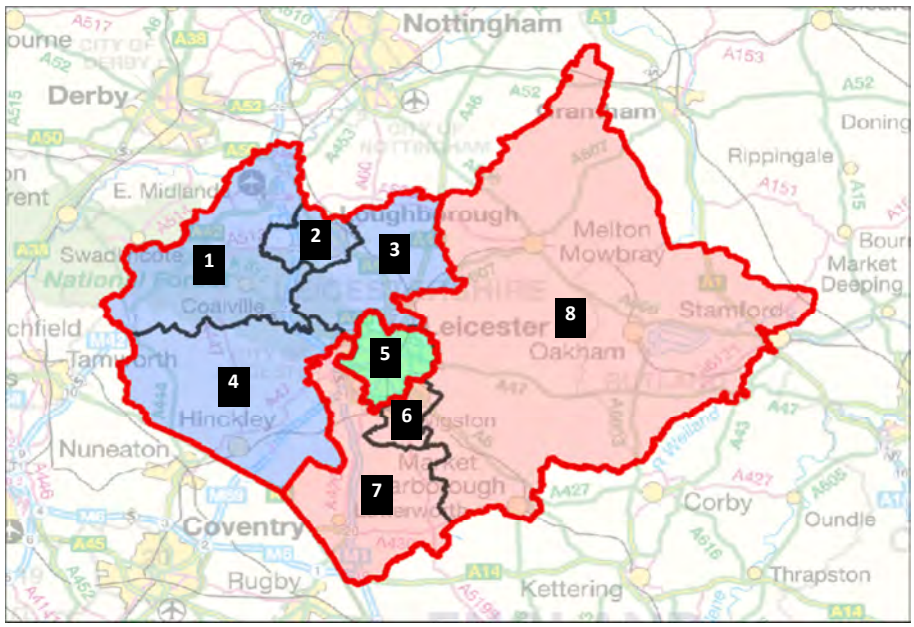
7. Annual Audit of Supervision of Midwives (2012/13) LSA Midwifery Officer.

8. Midwives Rules and Standards (2004) page 28. NMC(Nursing & Midwifery Council).

Appendices

1. **Map of Leicestershire**
2. **Birthrate Plus Acuity**
3. **Interview Questionnaire**
4. **Members of staff who were interviewed by the Obstetric Reviewer**

Appendix 1



West Leicestershire CCG

Leicester City CCG

East Leicestershire and Rutland CCG

Localities Key

Area Boundaries

1. North West Leicestershire
2. Charnwood North
3. Charnwood South
4. Hinckley and Bosworth
5. Leicester City
6. Oadby and Wigston
7. Blaby and Lutterworth
8. Melton, Rutland and Harborough

BIRTHRATE PLUS INTRAPARTUM ACUITY®

LGH Maternity Hospital

7 days : Week Commencing **09/07/2012**

Red	2+ mws short
Amber	1 and upto 2 mws short
Yellow	upto 1 mw short
Green	Meets acuity

STAFFING STATUS by COLOUR CODE & SHORTFALL

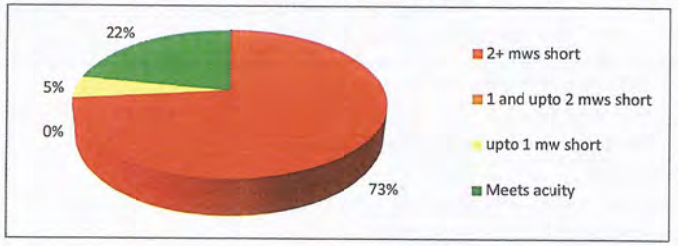
w/c 09/07/12	Monday		Staff	Tuesday		Staff	Wednesday		Staff	Thursday		Staff	Friday		Staff	Saturday		Staff	Sunday		Staff
	03:00	Red	-3.80	03:00	Red	-2.90	03:00	Red	-3.90	03:00	Green	NA	03:00	Red	-6.60	03:00	Red	-3.65	03:00	Green	NA
	07:00	Red	-2.00	07:00	Red	-4.10	07:00	Red	-7.70	07:00	Red	-2.90	07:00	Red	-4.75	07:00	Red	-3.20	07:00	Green	NA
	11:00	Red	-3.95	11:00	Red	-5.60	11:00	Red	-4.85	11:00	Red	-4.80	11:00	NR	NA	11:00	Yellow	-0.60	11:00	Green	NA
	15:00	Red	-1.60	15:00	Green	NA	15:00	Red	-6.50	15:00	Red	-6.60	15:00	Red	-4.40	15:00	Green	NA	15:00	Green	NA
	19:00	Red	-5.50	19:00	Red	-4.60	19:00	Red	-3.15	19:00	Red	-2.75	19:00	Red	-5.55	19:00	Yellow	-0.50	19:00	Green	NA
	23:00	Red	-8.70	23:00	Red	-4.10	23:00	Red	-2.30	23:00	Red	-5.55	23:00	Red	-6.15	23:00	Red	-1.90	23:00	Green	NA

Summary of weekly data:

Data recorded on 41 occasions *98%* *compliance*

No of occasions acuity identified as:

2+ mws short	Red	30	73%
1 and upto 2 mws short	Amber	0	0%
upto 1 mw short	Yellow	2	5%
Meets acuity	Green	9	22%
		41	*100%*



Notes:

Print date : 27/November/2012

Appendix 3

Leicester Maternity Service Review - 2012
General questions to promote discussion

NAME: GRADE: SOM: Y/N

YEARS IN TRUST EMPLOYMENT: YEARS IN NHS:

ABOUT THE SERVICE:

1. How do you and the Trust know what women want?
2. Do you have any concerns regarding the services to women?
3. How do you think service can be improved?

ABOUT YOU:

4. Your qualifications:
5. Who is helping you/is involved in your professional development?
6. Do you attend multidisciplinary meetings to discuss clinical care or policies? Give details:
7. Do you enjoy your work?
8. Who supports you in the tough times?
9. How do you access senior management?
10. Date of last appraisal: + or - experience. Outcome?
11. Date of last supervisory: + or – experience. Outcome?
12. What was the last NICE guideline you read?
13. Where are the clinical policies stored in your department?
14. Any concerns about your working conditions.
15. Magic wand with only '1 wish':
16. Future plans/ambitions:
17. How long do you think you will stay in your present post/midwifery?

Appendix 4

Members of staff who were interviewed by the Obstetric Reviewer

- Obstetrician & Gynaecologist, Medical Lead Women's Clinical Business Unit (CBU)
- Obstetrician & Gynaecologist, College Tutor (LRI Campus)
- Head of Midwifery/Lead Nurse and Interim Solution Plans
- Feto-maternal Medicine Subspecialist, Lead for Research
- Medical Staff Administration Manager
- Obstetrician, Labour Ward Lead for LRI (Part-time)
- Obstetrician, Head of Service for Maternity Services
- Consultant Anaesthetist, Divisional Director for Women's & Children's Services
- Obstetrician & Gynaecologist, Lead for CNST including audits
- Obstetrician & Gynaecologist, College Tutor (LGH Campus) & Risk Lead LGH
- Feto-maternal Medicine Subspecialist & Labour Ward Lead for LGH
- Neonatologist, Head of Service for Neonatology
- Obstetrician & Gynaecologist, Audit Lead LGH
- Obstetric Anaesthetist, LRI Campus
- Obstetric Anaesthetist, LGH Campus
- ST6 SpR O&G, SpR Rota Co-ordinator
- ST2 SpR O&G, SHO Rota Co-ordinator
- ST7 SpR, SpR Rota Co-ordinator
- Obstetrician & Gynaecologist, Risk Lead LRI
- Feto-maternal Medicine Subspecialist, Lead for Fetal Medicine

UHL Consultant Staff not available for interview were:

- Obstetrician & Gynaecologist LGH Annual Leave;
- Feto-maternal Medicine Subspecialist, Maternity Leave;
- Obstetrician & Gynaecologist, Maternity Leave;
- Professor of Obstetrics & Gynaecology

There are currently five locum consultants employed in the service and none was interviewed.
There are approximately 12 consultants who practise gynaecology only and were outside the terms of reference of this review.

10. PHASE FOUR

Commissioning and contracting of maternity service

10.1 Background

The 2010 government white paper, Equity and Excellence: liberating the NHS (DH 2010) reformed the structure of the NHS, charging groups of general practitioners to lead clinical commissioning, exercise control over public funding and improve quality and productivity in the NHS.

From 2013 Primary Care Trusts (PCTs) will cease to exist and be replaced by CCGs, organisations that will take responsibility for the buying, planning and performance management of contracts to deliver local health services. The shadow arrangement currently seen will allow CCGs to learn about issues and challenges that face commissioners and enable them start to build a portfolio of delivery that will be required as part of authorisation from 2013 onwards and to achieve the vision of more clinically led commissioning.

Appendix 1 shows the proposed new NHS structure in more detail.

10.2 Method

Two independent commissioners were identified to undertake a review of the strategy development, commissioning and contracting of maternity services across LLR. This was undertaken by:-

- Reviewing national policy, best practice and demographic data

- Scrutiny of documents including terms of reference, performance dashboard, agenda and minutes from recent meeting

- Conducting a series of semi - structured interviews with key individuals from PCTs / CCGs and provider services. The full list of interviewees is found in Appendix 2.

10.3 Findings

The findings are summarised and presented below:

Review of Best Practice:

Commissioning organisations are in a state of flux, with a variety of commissioning models seen in different areas.

Commissioning Maternity Services: A Resource pack to support Clinical Commissioning Group (NHS Commissioning Board, 2012) outlines:

- The authorisation process for CCGs includes the need for clinicians to be at the forefront of service design.

- There is an opportunity to redesign the whole pregnancy to early years pathway, with the potential for more primary care engagement and services such as preconception care and perinatal mental health services.

- Collaborative commissioning is required, with close working across CCGs, Health and Wellbeing Boards (leading on teenage pregnancy, breast feeding, weight management and smoking cessation for example) and the NHS Commissioning Board (leading on neonatal care and health visiting). Coordinating these interdependencies to ensure women receive a seamless service will be crucial and it is through primary care that CCGs are in a powerful position to monitor the extent of local joined up working.

- Maternity services are unique, they cannot be demand managed in conventional ways, and activity cannot be controlled through referrals. Whilst babies are mainly delivered in acute trusts, most of the care of women happens in the community with a high number of community and social care interdependencies.

- Through 2012/13 the DH has developed a pathway payment by results (PbR) system for maternity, with data templates and business rules. 2012/13 was a shadow year for maternity pathway pricing. At present the DH is asking for feedback about the maternity PbR pathway to inform the national implementation of the new maternity tariff, for antenatal, delivery and postnatal period. The financial impact of implementing tariff is as yet unknown.

10.4 Strategy and Commissioning findings

- Across LLR there is widespread change and transition to successor organisations. Three CCGs are now in existence; West Leicestershire CCG, East Leicestershire CCG and Leicester City CCG, with new management structures and leads including collaborative arrangements with new staff in roles with new responsibilities and relationships.

- During 2012/13, shadowing arrangements have been in place, allowing CCGs to lead through the commissioning cycle, with support from clustered PCTs. CCGs will take full responsibility for strategy development and commissioning of services from 2013 onwards.

- The lead officer / maternity commissioner is an Associate Director, heading up the Children and Families team and is now employed by West Leicestershire CCG, working across the 3 CCGs. The lead officer is a midwife with skills and experience in both hospital and community settings. Colleagues see this as important and of benefit to the strategy development and delivery.

- Good working relationships are described between the lead officer / maternity commissioner and provider service managers, which lead to integrated commissioning and ongoing strategy development and service improvements.

- There are good examples of joint integrated commissioning across strategy development, commissioning, quality and contracting, largely due to the lead officer/maternity commissioner. At present the arrangements are developing and need to be formalised.

- The maternity element of strategy and commissioning appears to be relatively isolated from other programme areas. The decision-making arrangements and governance do not appear to be part of the coordinating CCG's core governance structures.

- There is enhanced clinical engagement with GPs, through the CCGs and also the 2 pathway GPs for Women and Children (one for the city and one for the two counties). A key ongoing challenge relates to ensuring that GP commissioners engage in a meaningful way across the patch with strategy development, commissioning and contracting of maternity services.

10.5 Contracting findings

- The PCT acute contracts team has overseen spend and activity. However, the inability to demand manage maternity means this element of the UHL contract has not received much attention in terms of service redesign. This is not unusual in relation to maternity services.

- Although work has been undertaken and is ongoing to improve coding of activity and the quality of data, there are still issues related to data accuracy and flow.

- There has been significant work undertaken to understand existing patterns of referrals which has resulted in more clarity about coding and NZ activity. The total value of the UHL contract for maternity for 2012/ 13 is £37,530,240. Of this, £5,628,869 is community midwifery (activity). UHL described having very little information about activity related to this element of the contact.

- The increase in the birth rate has resulted in an increase in overall activity.

- Payment for maternity services has been through a combination of tariff for deliveries, outpatient activity (e.g. obstetric antenatal clinics) and unscheduled attendances, with block contracts / payments for midwifery delivered antenatal and postnatal care in the community.

- There are several complex challenges in relation to providing maternity services as there is wide variation in service user choice of pathway input and outcomes vary. There is a universal element to the pathway, but high intervention hospital costs are also commonly seen.

- There is a distinction between the contract team and strategy / commissioning of maternity services in the LLR structures.

- There are no detailed maternity service specifications, except for new services such as for the Homeless Asylum Seekers Specialist Midwife.

10.6 Quality findings

- There is a well-defined structure of quality monitoring, with a constructive relationship between the CCG quality lead for UHL and the provider.

- The maternity quality dashboard was developed by the strategy and commissioning team along with providers, and is part of the UHL quality schedule. It is monitored bi-monthly through the Women and Children's Clinical Sub Group and the Maternity Services Liaison Committee. This is detailed and changes in response to emerging issues. This was demonstrated by changes made in May 2012 through joint work with the commissioner, quality lead, SHA maternity lead and provider. One example of this related to cardiotocograph (CTG) interpretation and resulted in additional training for staff.

- The CCG quality lead is confident that measures are in place to ensure safe and effective inpatient delivery. Hospital deliveries take place across three sites. Lack of midwifery and obstetric capacity is managed by closing either of the 2 main units. This happens approximately 11 times a month and results in a poor experience for service users who do not deliver in the unit of their choice. The main reason for closures was cited as staffing restrictions. The need to close both sites to deliveries happens very infrequently (once in 2012/13)

- Formally all quality issues are fed through the UHL Quality meetings. At present not all quality issues are fed into the Women and Children's Clinical Sub-Group.

- Internally in UHL the Women and Children's division is seen as one of the most open and transparent in terms of relating serious incidents and never events.

- A diagram outlining the current commissioning and contacting arrangements can be found in Appendix 5a.
- A diagram outlining potential commissioning and contracting governance arrangements can be found at Appendix 5b.

10.7 Conclusions

Overall there are structures in place to ensure the commissioning of maternity services is safe and effective. Maternity services do not appear to have had much specific focus in terms of discussion about the whole UHL contract and are not seen as an area of high concern in terms of contract management. This may be because national high profile targets and activity management dominate overall discussions. There is now an opportunity to take a more in-depth commissioner view of service pressures and appropriate resource levels, based on the findings of earlier phases of this review.

There is a clear distinction between the contracting function and broader strategy / commissioning activity. This was built into the CCG design, but it may be appropriate to now review structures and to mainstream maternity reviews with other CCG governance and decision-making processes regarding service redesign. Some of the informal relationships between leads need to be formalised and delivered through the developing structures.

Implementing the new tariff will bring with it challenges and will require robust information systems in place to ensure correct financial flows for local women and women who deliver out of area. Several of the issues previously seen (e.g. NZ activity and coding the delivery of parent craft) will no longer be issues with the full implementation of tariff.

There was good evidence of undertaking actions to respond to quality issues in a responsive way (CTG reporting) and internally the maternity division is seen as one of the most transparent in terms of reporting serious incidents and near misses. This is thought to be because of the high NHS Litigation Authority insurance premiums paid for maternity services, at least in part. Community midwifery services do not appear to undergo the same level of scrutiny as hospital-based practices.

10.8 Recommendations

Following review of national policy and best practice and from undertaking semi-structured interviews with key stakeholder the review team has developed the following recommendations:

Strategy development and commissioning recommendations

1. Continue to strengthen and develop explicit links between strategy development, commissioning and contracting (finance, activity and quality). This may be achieved through increasing GP and CCG involvement from all 3 CCGs in the commissioning of the pregnancy to early years pathway. A vehicle to achieve this could be representation from CCG members on the new Women and Children's Clinical Sub-Group and through the lead officer / maternity commissioner being part of the contract performance meeting.

2. The CCGs need to ensure that the Women and Children's Clinical Sub-Group has ongoing clinical representation from all CCGs or a means of communicating with all main commissioning groups, and has the right of representation from contracting and quality teams.

3. Engage with GPs to develop the pathway in primary and community care, in particular in relation to booking by 13 weeks of pregnancy and post-natal care. All GPs need to work in partnership with midwives and midwives need fast access to GPs. Midwives need to be part of the overall primary care team and improve links with health visitors.

4. Ensure the experience of women and families using local services continues to be collected and that information is used to inform commissioning decisions.

5. Ensure UHL continues to share comprehensive data. All CCGs should continue to scrutinise the data in relation to maternity activity, capacity, targets and the new tariff.

6. Explore whether the Children and Families Team have sufficient capacity to deliver on the recommendations. This may be bolstered through enhanced GP engagement.

7. Service leads need to continue to ensure that formal reporting lines are followed, and ensure key messages are fed into the same formal route and follow the same commissioning cycle, feeding into CCG planning and prioritisation.

8. Ensure good relationships and partnership working develop between GP commissioners, public health, UHL and maternity service users.

Contracting recommendations

9**.** Implement local or nationally agreed service specifications for the antenatal, delivery and postnatal period.

10. Work jointly with UHL to develop mechanisms to use the antenatal, delivery and postnatal tariff with risk sharing arrangements agreed for 2013/14. This would allow data to be examined and explored and financial risks to be managed, ensuring learning from other commissioners who have implemented the PbR pathway.

11. UHL recognise data relating to the community element of the contact is a weakness and need to ensure a system is put in place so that they can accurately monitor community activity, quality and value for money.

12**.** Work should be carried out to ensure clear and common understanding of the new pathways for antenatal, delivery and postnatal care with definitions of standard, intermediate and intensive levels of care.

13. Ensure that the contract escalation process is agreed and documented in line with other programme areas.

Quality recommendations

14. Continue to work with providers to improve the quality of maternity services in both the hospital and community setting.

15. Continue to ensure service users are involved in monitoring the quality of services. This could be done through the Maternity Services Liaison Committee, with resources and skills identified to undertake the work.

16. Use the Women and Children's Clinical Sub-Group to learn from serious incidents and near misses and to develop actions to improve quality, ensuring links with the contract quality groups are explicit and supported.

17. Ensure that the frequency and reasons for closure of one of the two main birth units is understood and addressed as soon as possible, as closures result in an unreliable service for women who expect to be cared for in a particular environment.

18. Increase CCG support to the Maternity Services Liaison Committee.

19. Continue to monitor dashboards, CQUINs, quality reports and user experience. Regular dedicated time on the specific maternity service trends should be spent with the involvement of members of the Women and Children's Clinical Sub Group.

20. The dashboard and monitoring should be reported to the Quality Scrutiny Group and the Women and Children's Sub Group.

21. Use the Commissioning Maternity Services resource pack (NHS Commissioning Board, 2012) to ensure the pathway for women, babies and new families from pregnancy to early years is commissioned in a joined up way.

10.9 References

1. Department of Health (2010), Equity and excellence: Liberating the NHS

2. Department of Health (2012) Payment by Result guidance for 2012 – 13

3. NHS Commissioning Board (2012) Commissioning Maternity Services, a resource pack to support clinical commissioning groups

4. Speidel, J. J, Harper, C.C, Shields, W. C 2008. The Potential of Long Acting Reversible Contraception to Decrease Unintended Pregnancy. Contraception Journal. Accessed on line 17/12/12: http://www.arhp.org/publications-and-resources/contraception-journal/september-2008

5. Tyler, S. 2012: Commissioning Maternity services resource pack. Strategic maternity lead, NHS South of England

Appendices

1. Future NHS Structure

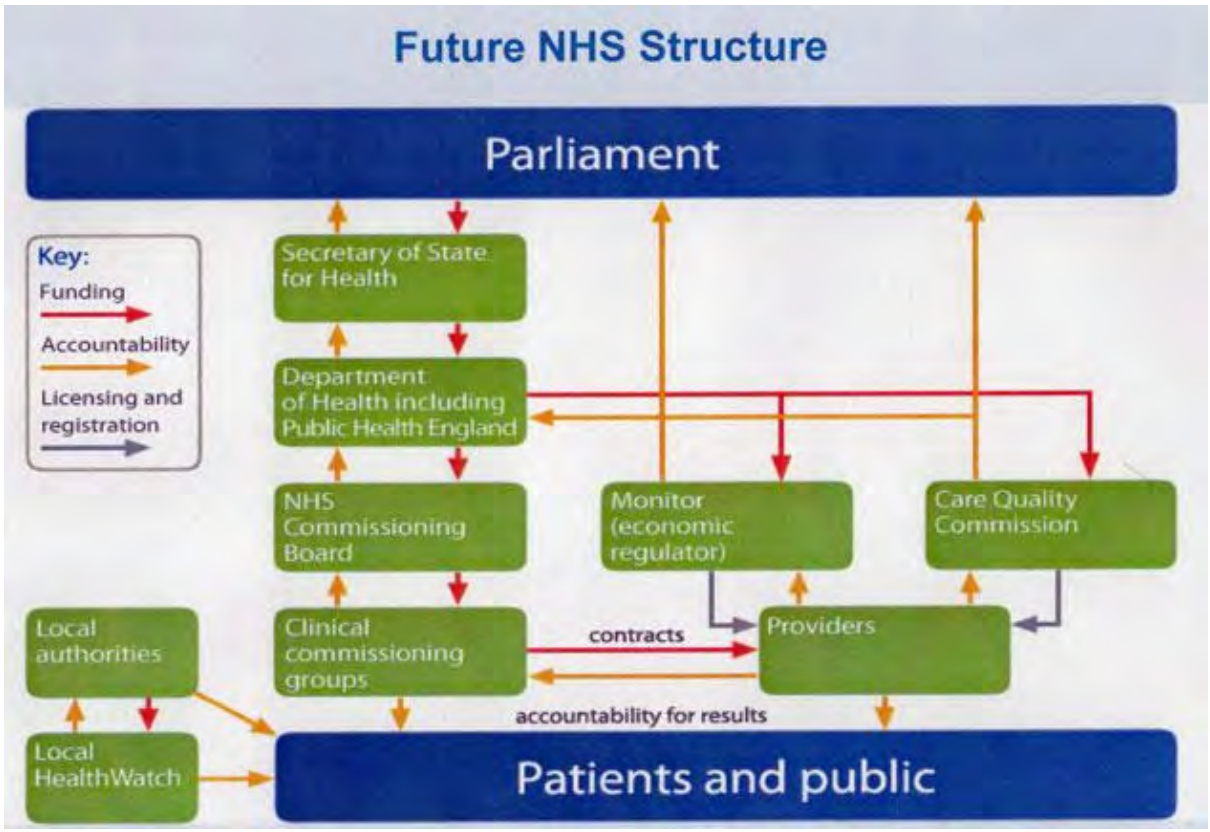
2. Interviewees

3. Minutes and Documents examined

4. Finances attached to the maternity element of the UHL contract 2012/13

5. a. Maternity Contracting Process
b. Maternity Strategy

Appendix 1


Future NHS Structure
Parliament
Key:
Funding
Accountability
Licensing and registration
Secretary of State for Health
Department of Health including Public Health England
NHS Commissioning Board
Monitor (economic regulator)
Care Quality Commission
Local authorities
Clinical commissioning groups
contracts
Providers
accountability for results
Local HealthWatch
Patients and public

Appendix 2

Interviews were conducted with the following people:

Simon	Freeman
Alison	Hassell
Gerraint	Jackett
Jane	Porter
Peter	Rabey
Mark	Sheppard
Mel	Thwaites
Caroline	Trevithick
David	Yoemanson

Appendix 3

Minutes and documents examined:

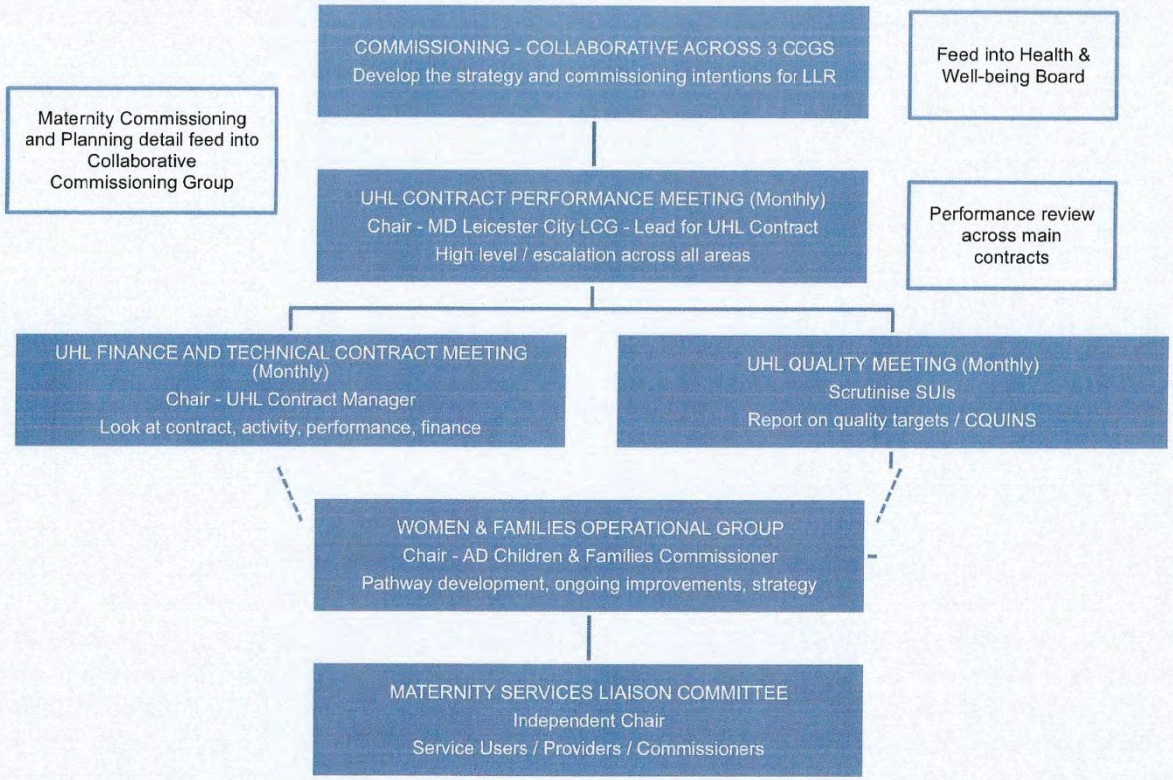
- Demographic data to support the external review of maternity services at University Hospitals of Leicester NHS Trust. Autumn 2012.
- Women's and Children's clinical subgroup ToR draft
- Maternity Dashboard (June 2012)
- MS1 Dashboard Q1 Exception report Aug 2012
- Maternity Access 2011 – 12 out turn as at 10 Oct 2012
- Maternity Operational Group draft 1C ToR
- Maternity Operational Group notes
- Maternity Operational Group agenda
- CCE MSLC Report Final Paper 1.doc
- MSLC draft notes March 2012
- MSLC draft notes June 2012
- MSLC draft notes Sept 2012

Appendix 4

Finances attached to the maternity element of the UHL contract 2012/13

Activity Type	Actual Management	National Specialty Description	Annual Plan (Activity)	Annual Plan (£)
IP	Inpatient	Midwife Episode	-	-
		Obstetrics	1	591
	Inpatient Total		**1**	**591**
	Emergency	Midwife Episode	45	28,846
		Obstetrics	12	16,407
		Well babies	2	2,723
	Emergency Total		**58**	**47,976**
	Non Elective	Midwife Episode	12,253	9,153,666
		Obstetrics	18,179	16,986,613
		Well babies	7,985	164,249
	Non Elective Total		**38,417**	**26,304,528**
IP Total			**38,476**	**26,353,095**
OP	New Outpatients	Midwife Episode	3	359
		Obstetrics	7,857	976,762
	New Outpatients Total		**7,860**	**977,121**
	Follow Up Outpatients	Midwife Episode	854	51,395
		Obstetrics	10,789	664,576
	Follow Up Outpatients Total		**11,642**	**715,972**
	Non Face To Face Outpatients	Midwife Episode	273	6,282
	Non Face To Face Outpatients Total		**273**	**6,282**
	Outpatient Procedures	Obstetrics	26,654	3,219,371
	Outpatient Procedures Total		**26,654**	**3,219,371**
	Follow Up Reduction	Midwife Episode	-	(10,133)
		Obstetrics	-	(5,857)
	Follow Up Reduction Total		**-**	**(15,990)**
OP Total			**46,430**	**4,902,756**
Other	Excluded Drugs and Devices	Obstetrics	-	3,429
	Excluded Drugs and Devices Total		**-**	**3,429**
	National Screening Programmes	Obstetrics	10,896	273,993
	National Screening Programmes Total		**10,896**	**273,993**
	Other	Community Nursing (Midwifery)	10,896	5,628,869
		Baby Friendly Initiative	-	26,800
		Homeless Asylum Seekers Specialist Midwife	-	87,645
		Maternity Support Workers	-	241,743
		Supporting Healthy Lifestyles & Weight Management	-	11,911
	Other Total		**10,896**	**5,996,967**
Other Total			**21,792**	**6,274,388**
Grand Total			**106,698**	**37,530,240**

Appendix 5 a: UHL MATERNITY CONTRACTING PROCESS – HERE & NOW November 2012



Appendix 5 b: BRINGING MATERNITY STRATEGY INTO THE CCGS

Moving into the Future, link maternity in with internal CCG governance processes to allow local variations / focus as required, planning, relationships to develop