Title: Maternity Services

Purpose: The aim of this paper is to provide the board with an overview of the proposed integrated model of midwifery care.

Summary: The National Service Framework (NSF) provides a clear direction for the provision of maternity services, with an emphasis on normality and improving outcomes for mothers and babies. The NSF clearly places women and their babies at the centre of care. The paper sets out the proposed strategy to deliver the requirements of the NSF and meet the recommendations from the Confidential Enquiry into Maternal Deaths (CEMACH) by revising the current model of midwifery care.

Recommendation: The Board is asked to discuss the approach outlined in the document and endorse the recommendations set out in paragraph 10 of the report.

Prepared by: Tracey Reeves, Peter Adey  
Presented by: Angela Pedder, Tracey Reeves, Peter Adey

This report covers: (Please tick relevant box below)

<table>
<thead>
<tr>
<th>Healthcare Standards (CORE – please specify which standard)</th>
<th>C7f C17</th>
<th>Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Standards (DEV’T – please specify which standard)</td>
<td></td>
<td>Finance</td>
</tr>
<tr>
<td>Service Development Strategy</td>
<td>X</td>
<td>Performance Management</td>
</tr>
<tr>
<td>Local Delivery Plan</td>
<td>Business Planning</td>
<td>X</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Complaints</td>
<td></td>
</tr>
<tr>
<td>Other (Please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: This paper/policy has been assessed for any equality, diversity or human rights implications.
EXECUTIVE SUMMARY INTEGRATION MODEL OF MIDWIFERY CARE

1.0 Purpose

The aim of this paper is to provide the board with an overview of the proposed integrated model of midwifery care.

2.0 Background

2.1 The National Service Framework (NSF) provides a clear direction for the provision of maternity services, with an emphasis on normality and improving outcomes for mothers and babies. The NSF clearly places women and their babies at the centre of care.

2.2 To deliver the requirements of the NSF and meet the recommendations from the Confidential Enquiry into Maternal Deaths (CEMACH) we need to revise our current model of midwifery care.

2.3 Locally all other services have implemented an integrated care model.

3.0 Current Service Provision

3.1 The maternity service operates in a traditional way. The RD&E employs 92.6 WTE midwives and delivers 2922 babies per annum. The hospital services provides support to high risk women and those developing intrapartum problems from East & Mid Devon birthing units.

<table>
<thead>
<tr>
<th>Year</th>
<th>RDEH</th>
<th>Tiverton</th>
<th>Okehampton</th>
<th>Honiton</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004 / 05</td>
<td>2639</td>
<td>117</td>
<td>56</td>
<td>151</td>
<td>3097</td>
</tr>
<tr>
<td>2005 / 06</td>
<td>2922</td>
<td>209</td>
<td>65</td>
<td>185</td>
<td>3514</td>
</tr>
</tbody>
</table>

3.2 Mid & East Devon

Directly employ their community midwives. The new proposed model would initially affect the women delivering at the RD&E and working in Exeter. (Exeter PCT does not employ midwives directly).
3.3 Currently we have 15 WTE midwives who work in the community. The hospital and community based services work separately. For the women they meet the midwife who cares for them in labour for the first time during labour. There is no continuity of care and one to one care is not always possible.

3.4 The community midwifery caseloads are high, above the LSA recommended level, skill mix in the service as a whole is poor with few support workers.

Concerns with the current model:

- Service is fragmented.
- Inequity for women and staff.
- Governance issues relating to the updating of staff.
- Women have told us via the NHS Live Project that the current model of care does not meet their needs regarding choice and continuity.

4.0 The proposed model

4.1 Primarily the new model will affect the 15 WTE community midwives and 17 WTE midwives from the current hospital based service.

4.2 The community will be divided by postcode (as the health visiting service is). Women will be allocated to a team of 8 midwives. The team will provide the total package of care including intrapartum care on a shift basis/on call basis.

4.3 The vision of the teams will be to promote normality and choice, continuity care approach with common evidence based clinical guidance.

4.4 The model from the woman’s perspective:

- Women will self refer to the midwife.
- Referrals will be collated centrally and allocated to teams in the children’s centre nearest to the woman’s home.
- Women will be seen early in pregnancy for health promotion and the complete the booking process in a location of their choice.
- All care will be evidence based.
- Parent education classes will be based in the children’s centre and involve the multi disciplinary team. For those who are more vulnerable this will be provided more on a 1:1 basis.
- When labour commences the woman will contact her team. The midwife on shift will assess the woman at her home and
if required accompany her to the labour ward. One of the
team will remain with her for all her labour and delivery.

- The team midwife will visit the postnatal women on the ward
  and provide the ongoing care in the home environment.
- Drop in sessions for breastfeeding women will be provided in
  the children’s centres.
## 5.0 Principles behind the current and proposed service

<table>
<thead>
<tr>
<th>NSF STANDARD</th>
<th>CURRENT PROVISION</th>
<th>RDEH PROPOSAL TO ACHIEVE NSF TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring women can access a midwife as their first point of contact</td>
<td>Midwives are attached to General Practice and the midwives receive referrals from the practice.</td>
<td>RDEH needs to promote this service. Posters in children’s centres, GP surgeries, advert in local press, flyers within children’s centre areas.</td>
</tr>
<tr>
<td>Maternity services should be accessible via a range of different “gateway” settings (including providing direct access to midwifery services)</td>
<td>Don’t currently meet this requirement.</td>
<td>Women will be able to refer themselves to services directly, referrals will also be accepted from a variety of sources such as health visitors, family planning centres, school nurses, social workers, housing etc</td>
</tr>
<tr>
<td>Provide women with a choice of where to receive antenatal care and the time and date of their appointments</td>
<td>No choice currently. AN care provided in set clinics in general practice surgeries.</td>
<td>Reduced caseload offering women a choice of time and location for their antenatal care e.g. children’s centre, home, GP surgery. Antenatal care will be individualised to meet the needs of the woman.</td>
</tr>
<tr>
<td>Provide continuity in care throughout pregnancy and through to discharge</td>
<td>Current system provides AN and some PN continuity but none for labour unless a home birth.</td>
<td>Named midwife will provide continuity where possible antenatally. The team will also provide group sessions to offer women the opportunity to meet the team.</td>
</tr>
<tr>
<td>Be provided as close to home as is reasonably possible</td>
<td>Not met – unless the practice is near where the woman lives.</td>
<td>All team midwives will be based in children’s centres and provide care for women who live within their immediate area.</td>
</tr>
<tr>
<td>Provide women with a choice over where and how they have their baby</td>
<td>Limited choice currently. Homebirth or hospital birth with no midwife continuity.</td>
<td>Clear team philosophy that promotes normality. Flexible antenatal care that allows time for discussion, 1-1 parentcraft, team birth preparation classes.</td>
</tr>
<tr>
<td>NSF STANDARD</td>
<td>CURRENT PROVISION</td>
<td>RDEH PROPOSAL TO ACHIEVE NSF TARGET</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provide women with a choice of pain management appropriate to the setting in which they have chosen to give birth</td>
<td>Women are offered all types of pain relief. However, the current model of care does not promote 1-1 labour care.</td>
<td>All midwives will be skilled in managing birth in both low and high-risk setting. All midwives will be updated in managing all types of pain relief. Homebirth training will be provided for hospital midwives.</td>
</tr>
<tr>
<td>Provide women with a choice of where to receive postnatal care and the time and date of their appointments.</td>
<td>PN visiting is routine. The Community Midwives provide home visits.</td>
<td>Women offered a choice of time and date for postnatal visits. Postnatal drop in &amp; breastfeeding clinics available in children centres. Increased links with Health visitor.</td>
</tr>
<tr>
<td>Services need to be proactive in engaging all women particularly those from disadvantaged groups.</td>
<td>The current model is gate kept by the GP practices.</td>
<td>Midwives will be flexible in their approach to providing antenatal care. For those women identified as vulnerable antenatal home visits will be offered as routine. Via multi disciplinary working encourage women to attend support groups in children’s centres.</td>
</tr>
<tr>
<td>Every woman to be supported by a named midwife throughout her pregnancy</td>
<td>Current system enables continuity antenatally but not for labour.</td>
<td>Booking completed by named midwife who will lead on antenatal &amp; postnatal care, attendance at key Consultant antenatal appointments.</td>
</tr>
<tr>
<td>Support will be linked to other services that Will be provided in Children’s Centres</td>
<td>Currently use 2 of the children centres.</td>
<td>Co-location of integrated teams to children’s centres.</td>
</tr>
</tbody>
</table>
6.0 Financial Impact

6.1 By 2008/9 it is proposed that Revenue income for community Maternity Services will shift from a block contract to a national tariff. Maternity services is one of the first areas for the more detailed work to be completed. By implementing the new model and tracking activity more careful we will be in a good position to maximise income.

6.2 Financial modelling has been undertaken, there is a potential (current N12 activity) loss of income due to home labour assessments. However, the PCT has agreed in principle to risk share, although this needs formal agreement. The model costs no more money to provide but has significant quality, equity and outcome benefits.

7.0 HR Impact

7.1 The new model requires a significant cultural shift for the service.

However, a considerable amount of preparatory work has been undertaken.

- New hospital rotation.
- Revision of hospital midwifery and support worker staffing numbers.
- Relocation of community midwives from hospital base into children's centres.
- Midwifery restructure.
- Participation in national support worker development (DoH led).
- Revision of staff communication.

A detailed HR implementation plan is in progress.

8.0 PPI Impact

Service users have been involved in the NHS Live Steering Group. Implementation of the revised model of care has been heavily supported over the last 2 years. The NHS Live Group with user representation will act as a steering group for the work.

9.0 Timescale

The model to be implemented by January 2007.
10.0 Recommendations

10.1 The new model is evidenced based and will enable us to meet KSF targets.

10.2 Most importantly it enables us to meet the needs of service users in a flexible way, providing evidence based quality care based on need.

10.3 The proposed revisions for PbR will support the model and enable the RD&E to secure appropriate income to provide the service. Reverse incentives such as N12 will go and the new model will ensure we are paid for provision of the service.

Tracey Reeves
Head of Midwifery & Deputy Director of Nursing