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Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee
County Hall
New Road
Oxford OX1 1ND

17th December 2018

Dear Councillor Fatemian

Thank you for your letter of 29th November to our Chief Executive Gill Walton and for the invitation to speak at the Horton HOSC meeting on Wednesday 19th December. I will be representing the RCM at that meeting and look forward to discussing the proposals for the future of services at the Horton.

In advance of this meeting, I set out in this letter, the RCM's views on the proposals for services at the Horton and, in particular, our response to the questions outlined in your letter.

I thought it would be helpful to begin with an explanation of the RCM's approach to responding to proposals for reconfiguring maternity services. As set out in the attached position statement, we believe that proposals for merging or reconfiguring maternity services should:

- Be supported by a robust and evidence-based case for change.
- Ensure that women are able to choose where to give birth, including the options of giving birth at home or in a midwife led unit (MLU).
- Include information, in a variety of formats, about all the available maternity facilities.

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- Demonstrate alignment between the proposed model(s) of care and the needs of women and babies, staffing and skill mix levels, the demographic profile of the local population and case mix.
- Maximise the opportunity for women to have continuity of carer from the person who is caring for them.
- Encourage multi-professional working and learning.
- Ensure that there is sufficient capacity to deliver services in the new or modified settings.
- Include robust arrangements for the safe and timely referral and transfer of women and babies to more specialist services, when these are required.

Options for an obstetric unit at the Horton General Hospital

Of the options listed, if there is no improvement in efforts to recruit middle grade doctors to the Horton (and accordingly no restoration of training accreditation) then the RCM's preferred option would be option Ob4 (single obstetric service at JRH).

The standalone MLU at the Horton achieved 200 births in its first year, which provides a good basis for its future. Although latest statistics indicates a slight fall (190 births in the last year) this is reflective of an overall reduction in birth numbers in Oxfordshire. Ideally, standalone MLUs should be achieving 400 or more births a year; we are therefore pleased that there are plans to promote the MLU in order to increase the number of women that access services there.

If the recruitment and training issues affecting medical staffing are resolved, then the RCM would in principle support option Ob7 (two obstetric units both with an alongside MLU). We regard option Ob7 as preferable to the other options that are based on two obstetric units, as none of these explicitly commit to also having MLUs on site. It should be noted that while the RCM supported the temporary reconfiguration of maternity services, we have always been concerned about the distance that women in Banbury have to travel to attend the maternity unit at the JRH. Restoring obstetric services to the Horton will benefit those women who would not be eligible to access care from a standalone MLU, but we must stress that this will only be a realistic option if there is a significant improvement in the recruitment of middle grade doctors and the restoration of training accreditation.

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The RCM would also like the Horton HOSC to give consideration to the option for women to give birth at home, which appears to have been overlooked in all of the options listed. As part of the transformation of maternity services in England, commissioners and providers are meant to ensure that women are offered choice of a birth in hospital, in a midwife-led unit and also birth at home. The best way of enabling this option to be available to women is to develop a service model based on:

- An organisational commitment to support the home birth service.
- Employing sufficient numbers of competent and appropriately educated midwives.
- Ensuring that the woman knows at least one of the midwives attending her home birth and that she has her contact details.
- Clear and agreed standards for the transfer of women from home, in case of delays or complications.

Work undertaken on recruitment and retention of staff at OUHFT

Based on Dr Veronica Miller's report on midwifery and medical staffing recruitment, while the recent recruitment drive for midwives appears to have been successful, we note that maternity services are predicting staffing shortfalls for next year and that this is likely to be confirmed by the Birthrate Plus assessment (the initial findings of which are already indicating a shortage of midwives for the workload and acuity of the women attending the JRH). The question then is not whether OUH is able to recruit midwives to posts but whether its funded establishment accurately reflects the number of midwives needed to deliver a safe and good quality service.

On medical staffing, the report does not appear to offer many grounds for optimism that the Trust can achieve a significant turnaround in recruiting more obstetric staff. While the present shortages persist it is difficult to see how obstetric services can be restored at the Horton.

Acceptable and safe midwifery staffing levels for an obstetric unit

The RCM recommends adherence to the NICE safe staffing guideline for midwives working in maternity settings as the most appropriate guidance for determining what are acceptable and safe midwifery staffing levels. The key recommendation within the guideline is that there are sufficient midwives to provide every woman in established labour with one-to-one care from a midwife. This must always be calculated on the total number of clinical whole time equivalent (wte) midwives required exclusive of specialist and managerial roles.

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This will include allowing uplift to account for:

- Sickness absence, maternity leave and study leave.
- Continuous professional development.
- Training required to maintain competency in providing safe maternity care.
- The supervisory and managerial duties of senior midwives.

It is absolutely essential that implementation of the guideline is underpinned by a systematic workforce strategy and use of a recognised workforce planning tool for determining the total number of midwifery and MSW staff required. This will vary from maternity service to maternity service and will depend on a range of variables, such as models of care, configuration of services, case mix, length of stay in acute settings and competency levels of maternity support workers.

All services will be subject to peaks and troughs in demand throughout the year, so workforce planning will need to be augmented by acuity tools and escalation plans in order to ensure that services respond promptly to sudden fluctuations in activity or changes to staffing levels (caused for example by unexplained absences). Whilst the labour ward should be safely staffed at all times, this should not be at the expense of other areas, such as community or home birth services.

The RCM strongly recommends using Birthrate Plus to undertake workforce planning for midwifery services, as this is the only recognised national tool for calculating midwifery staffing levels. Birthrate Plus provides a robust and proven methodology, based on the minimum quality standard of providing one-to-one care in labour, and has been endorsed by NICE.

In line with the recommendations in Better Births, and the current maternity transformation programme in England, the RCM recommends that staffing levels should not only be based on women receiving one-to-one care in labour but should also be sufficient to ensure that models of service delivery based on continuity of carer can be developed.

Benefits and challenges for midwives providing care in small obstetric units

While there is little evidence to say what the optimum size of an obstetric unit should be, it is likely that units undertaking more than 8,000 births a year may require staffing by two teams of obstetricians. The RCM also believes that maternity units undertaking fewer than 6,000 births a year are more likely to facilitate an environment in which care is personalised and woman-centred.

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While we recognise that the smallest maternity units (particularly those undertaking fewer than 2,500 births a year) face challenges in terms of attracting sufficient numbers of trained medical staff to make them viable, it should also be recognised that the closure of small units will have an impact on the capacity of neighbouring units. In addition there is a strong case (recognised within Better Births, the report of the national maternity review in 2016) for retaining small maternity units in remote and rural settings in order to avoid a situation where women and families are required to travel long distances to access their nearest services.

Accordingly, if the future of an obstetric unit is subject to review, consideration should be given to:

- The impact that a closure would have on local women, particularly in terms of the time and distance that they would then need to travel in order to access neighbouring maternity services.
- The capacity of neighbouring units to absorb the additional activity resulting from the closure of the unit.
- Whether, particularly in the case of smaller obstetric units, arrangements can be made with a larger unit for referral of women and the interchange of staff
- Establishing a midwifery-led service on the site of the obstetric unit.

It is unlikely that small obstetric units will be able to provide care to the most high risk women, so there must be adequate plans in place to ensure that these women are able to access appropriate care from specialist maternity services. It is therefore vital that smaller obstetric units undertake continuous, dynamic and robust risk assessment for all women, that there is appropriate signposting to the most appropriate setting of care and that this is all underpinned by excellent stabilisation and transfer services¹.

Examples of innovative practice which allows smaller obstetric units to be run and staffed, safely and sustainably

The examples that the Committee are interested in probably relate more to innovative practice in obstetric staffing than midwifery, and may therefore be one that the RCOG is better qualified to answer. Having said, that the RCM is aware of the case of West Cumberland Hospital (WCH) in Whitehaven - another small obstetric unit (1200 births a year), where the RCOG had recommended the incorporation of new ways of working as a means of sustaining the unit.

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This included adopting a networked approach, within which WCH was linked to the nearest obstetric unit at Carlisle and the tertiary service at Newcastle. This model was seen as facilitating the amalgamation of medical staffing structures through the rotation of consultants between Whitehaven and Carlisle. This networked approach was also seen as beneficial in terms of addressing skills preservation and updating, CPD requirements and improving team working and communication (which could be extended over time to paediatric and anaesthetic services).

Comparison of alongside and standalone MLUs

Whilst alongside and standalone MLUs have distinctive characteristics and facets, it is worth emphasising that they also share much in common. The principles and evidence for the provision of care are much the same for both types of MLU – both provide care to healthy women with straightforward pregnancies during labour and following birth. And both provide care that is as safe as in obstetric units for low risk women, including women expecting their first babiesⁱⁱ. It should be noted in any case that all births, wherever they take place, carry some risk – however small – and the key issue here is informed choice for women. Women who birth in MLUs are more likely to have a normal birth, to have access to water for pain relief and to successfully establish breastfeeding.

There is no recommended minimum or maximum level of activity for MLUs, whether alongside or standalone. For both models, staffing levels and skill mix should align with the number of women birthing in the MLU and with antenatal and postnatal activity – in order to ensure that the MLU is financially viable. Selection criteria and practice guidelines for MLUs should be agreed by the multi-disciplinary team and audited on a regular basis.

Alongside MLUs can provide a most cost effective and efficient use of the midwifery and MSW workforce, as they can be deployed flexibly within the whole service, particularly during times of peak activity. Alongside units should be staffed by a midwife-led team and supported by strong local leadership. They should offer sufficient capacity to meet the needs of the majority of low risk women and deploy a flexible staffing model in order to ensure that it can remain open even during times of high pressure on the acute unit.

Alongside units should be physically distinct from the delivery suite. Simply putting up a dividing curtain on a ward is not sufficient in itself to qualify it as an alongside MLU.

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The proximity of alongside units to obstetric services offers is an obvious advantage in situations where a woman may need to be transferred to obstetric care. On the other hand there are anecdotal concerns that 'risk-creep' can occur in standalone units i.e. because there is quick access to obstetric services, staff in alongside units may develop a higher tolerance to 'deviation' from the normal pathway than that which would be tolerated in community settings.

Standalone MLUs offers increased choice for some women as well as additional capacity, particularly when the nearest maternity unit is experiencing peaks in demand. Standalone MLUs are not just there for the birth but also provide antenatal and postnatal care, including for women who birth elsewhere. In some areas hospital obstetricians attend and run their clinics in the birth centre, thereby reducing the need for women to travel to the obstetric unit. While standalone units are by definition separate to an obstetric service, there is no reason why they cannot be co-located with other health and social care services, such as children's services, physiotherapy, health visiting, dentistry, GP and practice nurses.

There may be a strong case for commissioning a standalone MLU if an obstetric unit is due to close or if the nearest alongside MLU is a significant distance from the local community. Consideration should therefore be given to providing antenatal and postnatal care at the standalone unit for women at all risk levels.

Standalone units will not be right for everyone. Women cannot be offered all available pain relief in standalone MLUs and so a hospital setting may be more appropriate if the woman wants to be in a location where all the choices of pain relief are readily available. In areas of high deprivation, a standalone unit might not be considered to be viable if a significant proportion of childbearing women may be deemed to be at high risk, and therefore not likely to meet the criteria for birthing at a standalone unitⁱⁱⁱ.

Summary of clinical standards for midwifery which would be important for assessing the safety of an obstetric service

Crucial reports and strategic reviews about the quality of maternity care in different parts of the UK have consistently identified that improvements should be underpinned by implementation of existing evidence-based clinical standards.

The RCM standards for midwifery services in the UK cite 55 standards all of which cover safety in some way. The standards can be found here:

https://www.rcm.org.uk/sites/default/files/RCM%20Standards%20for%20Midwifery%20Services%20in%20the%20UK%20A4%2016pp%202016_12.pdf

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The RCM has identified six key themes for service delivery:

- Clinical governance.
- Communication.
- Staffing.
- Education and accountability.
- Family-centred care.
- Care and the birth environment.

Key measurement criteria are suggested for each standard, along with an example of at least one suggested source of evidence that could be used to evaluate implementation.

The RCM would draw the Committee's attention to the following standards in particular:

- Standards 6 and 7: High quality midwifery services nurture and develop a trusting relationship with the women and families that they serve. They work in collaboration with all key stakeholders in the provision of maternity care and engage proactively with service users, ensuring that feedback is responded to in a timely manner and that their views are sought when any significant changes to systems are proposed. They foster a culture of learning and supportive work practices amongst professional colleagues and are open and transparent in response to an investigation of any critical incidents.
- Standard 8: Midwifery is defined as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views and working in partnership with women to strengthen women's own capabilities to care for themselves”.
- Standard 9: A midwifery model of care assumes that pregnancy, birth and the postnatal period are normal life events for a woman and her baby.

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It is woman-centred and based on strong evidence that continuity of carer in monitoring and promoting the physical, psychological and social well-being of the woman and family throughout the childbearing cycle is critically important. A midwifery model of care provides the woman with individualised education, counselling and antenatal care, and continuity of care during labour, birth and the immediate postpartum period and ongoing support during the postnatal period. The midwife plays a central role in co-ordinating care and linking with other health and social care professionals and voluntary sector organisations providing services for childbearing women (adapted from International Confederation of Midwives 2011).

- Standard 10: This definition clearly places the midwife in a central position in both providing care and communicating with other family members, providers and clinicians. The care from a midwife will take place in many diverse settings and as such requires midwives to be adaptable and versatile.
- Standards 11 to 14: Midwifery care should take place within services which are organised to provide evidence-based guidance for midwives and in systems that validate and regularly review policies, guidelines and protocols. Services should use systems to continuously audit and monitor clinical activity and are reviewed regularly as part of the governance arrangements and adhere to professional standards for documentation, record keeping and data information storage. They should address the requirements of national guidelines and policies with particular regard to improving health and reducing health inequalities.

The RCM hears from women all over the UK about their birth experiences and they often report greater levels of satisfaction with midwifery units than receiving care in traditional labour wards. The care they receive is often more personal and they are less likely to experience medical interventions, such as caesarean sections. The RCM has always stressed that women need to make their decision about where they give birth based on the best possible evidence about the risks and benefits of all places of birth including home, midwife led units or in a consultant led obstetric unit. This is why it is so important that midwives have the time to discuss all the options about place of birth with women.

The other possible issue is that if the woman's circumstances change during the pregnancy such as anticipating themselves or their baby risk developing complications, they will then be advised to labour and give birth in hospital anyway. In addition, women are free to change their mind at any point if they wish to receive care elsewhere.

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I hope that you find this information to be helpful and I look forward to attending the meeting on Wednesday.

Yours sincerely

Gabby Dowds-Quinn
Regional Officer
Royal College of Midwives

ⁱ It should be noted that women who need to be transferred from an alongside MLU usually do so further on into their labour, than women who have decided to have their baby in hospital. It should also be stressed that the vast majority of transfers are not urgent and are conducted in planned and very controlled circumstances.

ⁱⁱ The Birthplace study in 2011, which was the definitive study of the safety of place of birth for women in UK settings, found that midwife led care, for women at low risk of complications, was as safe as a hospital birth, as well as reducing intervention rates. This is one of the key reasons that NICE amended its guidelines on the subject. The study also covered freestanding midwife led units.

ⁱⁱⁱ Only those women without risk factors fit the criteria for birth in a standalone MLU. These women would need to give consent, including understanding the distance to hospital if a transfer is needed.

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