Thames Valley Clinical Senate
Maternity Stakeholder Forum - 22nd November 2016

Introduction

The Thames Valley Clinical Senate has been asked to respond to the following question:

'Is the capacity and capability of maternity services within the Thames Valley (including Milton Keynes) sufficient to respond to demand over the next 10 years?'

In response to the question, the Thames Valley Children & Maternity SCN (the SCN) has completed a capacity report which reviewed the future need and has identified that there will be a shortfall in capacity within the next 10 years of circa 3,000 births.

The SCN noted that it is difficult to accurately predict a future birth rate taking into account new housing developments, major transport improvements and, potentially, the impact of Brexit. Accepting that the predictions cannot be totally accurate, the report identifies that there will be a need for additional capacity in each health system across the Thames Valley but that it will vary by geographic area. *(see table 3)*

In order to respond to the question posed, the Senate recommended that further detailed work was required to:

1. understand the initial response of each health economy to the growth prediction
2. identify the options available to the health system
3. carry out a whole system review of each of the options available to meet the predicted growth

The Senate therefore facilitated the stakeholder forum to engage the system in this work.

Maternity Stakeholder Forum (the Forum)

In line with the function of the Senate, the Forum was asked to work on a whole system basis to ensure that across the geography:

- services will be sustainable
- services will be accessible and of a high quality enhancing the patient experience
- any proposed service change clearly articulates the benefits to patients
- services will be based on a clear clinical evidence base

The purpose of the Forum was to:

1. hear initial plans from each health economy to respond to the projected increase in births
2. consider the potential to increase capacity strategically across Thames Valley
3. consider the potential to develop other options to meet the projected need
4. identify interdependencies for each of the considered options
5. assess the opportunities and risks of the options

This document is a report of the Maternity Stakeholder Forum held on 22nd November 2016.

1. Maternity Services

1.2 Maternity Stakeholder Forum (the Forum)

The Forum was held on 22nd November 2016. Attendance at the workshop is detailed in Appendix 1, and there was a good mix of user representatives, clinicians, service managers, commissioners, Senate representatives and Senate staff.

The question posed to the Forum was:

How can we respond to the rising birth-rate in the Thames Valley ensuring that across the patch choice is available for women and that resources are used in the most effective way (for high and low levels of activity) to deliver an equitable and sustainable service?

1.3 Current Provision and Predicted Growth

Current maternity provision across Thames Valley and Milton Keynes allows for all options of choice of birth, however not all options are available in all areas. All trusts are currently able to provide appropriate levels of maternity service, but there are peak times when some units are forced to divert or close to maintain a quality service.

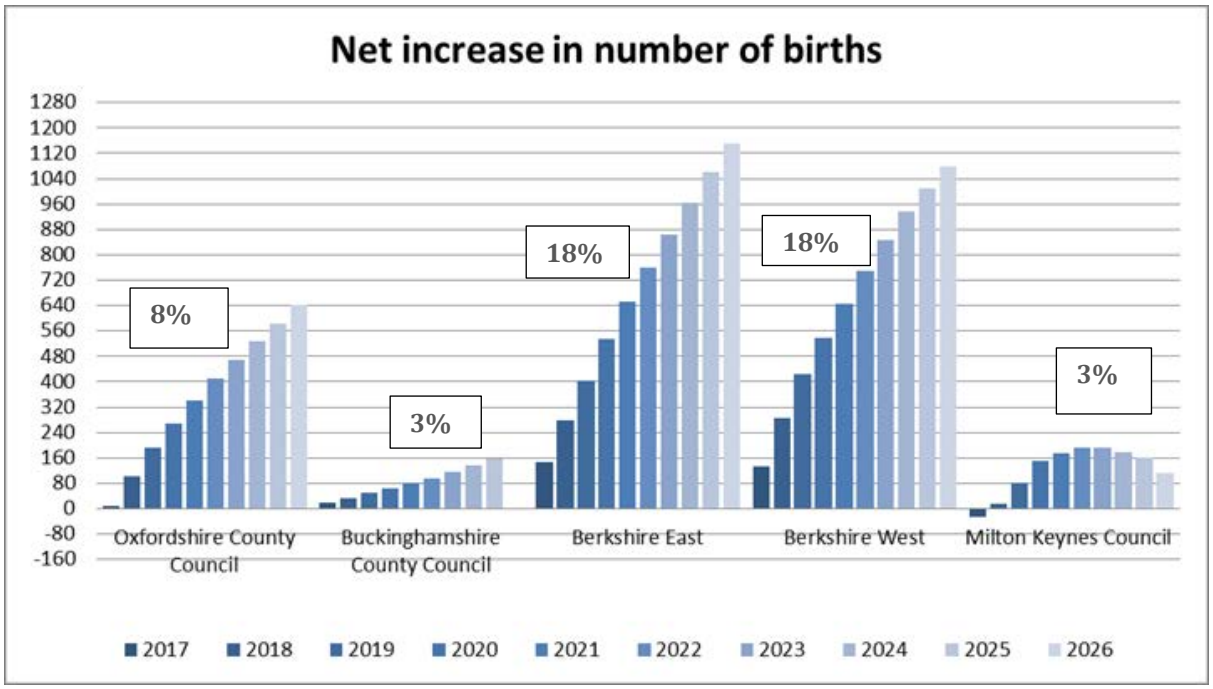
Table 1: Range of Services across Thames Valley

Services	Bucks	OUH	Milton Keynes	RBH	Frimley Park
Obstetric Unit	Stoke Mandeville	John Radcliffe	Milton Keynes	RBH, Reading	Wexham & Frimley
AMU	Stoke Mandeville	John Radcliffe	No	RBH Reading	Wexham & Frimley
FMLU	High Wycombe	Banbury	No	No	No
Home Births	Yes	Yes	Yes	Yes	Yes
Local Neonatal	Stoke Mandeville	John Radcliffe	Milton Keynes	RBH, Reading	Wexham & Frimley
Intensive Neonatal	John Radcliffe	John Radcliffe	John Radcliffe	John Radcliffe	John Radcliffe
Specialist obstetric Unit	John Radcliffe	John Radcliffe	John Radcliffe	John Radcliffe	John Radcliffe

Table 2: Activity (2015)

Services	Bucks	OUH	Milton Keynes	RBH	Wexham Park	Frimley Park
All Births	5532	8553	4033	5539	4292	5600
Obstetric Unit	4040	7095	3912	4561	3389	5407
AMU	1068	874	n/a	891	774	750
FMLU	369	409	n/a	n/a	n/a	n/a
Home Births	55	175	121	87	129	143

Table 3: Projected increase in births over the next 10 years



Thames Valley Children and Maternity SCN, Capacity Report June 2016

Workforce is of concern with 26.2% of midwives and 22% of obstetric staff being 50+ years old and potentially approaching retirement (55). The SCN identified that innovative thinking about the future of the workforce is required in order to address the loss of a significant proportion of experienced staff in the next ten years. This is of particular concern when births reach the level where there is a need for consultants 24/7.

All trusts are currently able to work to a midwife/birth ratio of 1:30, and all trusts use the RCOG good practice guidelines for Consultant Obstetric hours per week.

2 Known plans

2.1 Royal Berkshire Hospital

West Berkshire currently delivers 5595 women a year: 16% in Midwife Led Units, 1.25% at home. The Trust has experienced an increase in women with comorbidities and complex conditions, with twice the number of deliveries under consultant care and twice the number of visits to day unit services in comparison to ten years ago. There has also been a notable increase in the age of women giving birth with the average age of their first time mum being 31. 45% of women giving birth at the RBH were not born in the UK and the Trust is working towards better accommodation for ethnic diversity, and encouraging the inclusivity and uptake of services, including community services.

The RBH is experiencing difficulty in recruiting staff at all levels within both midwifery and medical staff, and there are times when they are forced to divert in order to maintain a safe quality service; there is a constant balance between allowing choice versus the safety of one woman compared to the safety of many.

Recruitment problems have been compounded by the loss of the midwife bursary; trainees are not choosing to work in a traditionally expensive geographic area. The Trust currently has provision for 116 consultant hours with plans to increase this to 168 by 2019 when deliveries are forecast to exceed 6000.

Thoughts for the Future

- the RBH building and facilities are currently unfit for purpose and the ideal option would be to build a new, fit for purpose building though given financial constraints, it is more realistic to expect to reconfigure the current building
- there are thoughts about building an FMU at the community hospital in Newbury which might have benefits for South Oxfordshire
- with the 17% predicted increase in births, a second theatre at the RBH will be required by 2019
- looking at how to optimise pre-pregnancy education
- considering resident on call consultant to improve recruitment

2.2 Buckinghamshire Hospitals

The Trust is concerned about the low predicted increase in births for Buckinghamshire as 1400 of its deliveries are from central Bedfordshire and Hertfordshire where the growth rate is 13% compared to the 3% predicted for Buckinghamshire. Following the temporary change to the Banbury service, it has seen 280 deliveries move to Buckinghamshire emphasising the mobility of women in response to change within individual services. Milton Keynes has the highest home birth rate across the Thames Valley.

The Trust has recently reconfigured its services and has been able to increase capacity; it currently delivers around 5800 women per annum and if it continues to accept women from outside its catchment its births could reach 6000 or even 6500. The Trust expects the out of area deliveries to continue and is anticipating a significant increase from the London population moving into the more affordable Buckinghamshire.

Challenges

As well as the population rise, significant challenges are:

- the increasing maternal age and number of women with complex conditions
- the alterations to the transport infrastructure altering patient flow
- the need to provide maternal choice
- the high proportion of rural areas in the patch
- the need to respond to regional capacity issues

The Trust benefits from having physical space to expand, scalable staffing via the use of reconfigured silo rotas, and a good location. Ideally, Bucks would like to keep services accessible and close to home, whilst enlarging to serve their community and those around them. What is happening on their borders is of significant importance.

2.3 Oxfordshire University Hospitals

Total births were 8,400 (14% at the Horton) and these overwhelmingly came from within the Oxfordshire area. The Trust has a large neonatal Level 3 NICU which accommodates babies from across the Thames Valley.

There have been difficulties recruiting to mid-grade positions at the Horton General Hospital which has resulted in the temporary closure of the obstetric unit there and it has temporarily been replaced with a freestanding midwife led unit (FMLU). This has meant that capacity at the JR has been geared up to accept an additional 1000 births in a short space of time – the equivalent of 2 or 3 years growth in the space of 4-5 months. This has put pressure on facilities: more birth rooms, more assessment areas and more postnatal beds were required in a building that was difficult to reconfigure. Due to the building's age, there are consistent issues with concrete, asbestos, and old technology.

The JR is a tertiary centre with provision for high risk and foetal medicine, and therefore requires senior medical staff. These posts are difficult to recruit into, and the hospital currently requires significant consultant expansion.

Women's choice in Oxfordshire is overwhelmingly in favour of obstetric units, and uptake of FMU delivery is low. Women who are low-risk and out of area do not get the options to give birth in the obstetric-led unit at the JR. Research has shown that women don't mind travelling to the JR for delivery, but dislike travelling there for diagnostics and assessment so more effective use of primary care services would be the ideal way to provide more convenient assessments.

Thoughts for the future

- a number of births at the Horton are from South Warwickshire and it's likely they will be repatriated
- estimates are that 250 women per annum will choose the FMU at the north of the county
- there is a requirement to increase capacity at the JR
- look at different ways to provide antenatal care - local services with partnership with primary care
- given the difficulties with modifying the old building, a new build would be preferred
- in the future, in order to continue to provide the specialist services, the Trust may have to refuse women from outside the area who choose the JR as their place of birth
- challenges with recruitment will continue

2.4 Frimley Health (Wexham)

Wexham is currently undergoing a £10 million refurbishment of the obstetrics and gynaecology unit which will future-proof the service to allow an increase of up to 6000 deliveries. The Trust is forecasting 4,600 births this year but are expecting that once the improved facilities are publicised, they will attract back some of their local population who may have chosen other facilities in the past.

There is also a £2.3 million refurbishment ongoing at Frimley Park which will provide a new labour ward and alongside midwife led unit which, as with Wexham, will give capacity for up to 6,000 births

per annum. The current birth projection at Frimley Park is 5,600. The AMU has proved to be popular at Frimley with both women and staff and they are hoping to replicate this success on the Wexham site.

The infrastructure is now very sound, but staffing remains challenging as obstetrics has become a less popular speciality to go into as it has regular on-call shifts and this is increasingly unappealing when people are expected to work until the age of 70. They have experienced significant difficulties recruiting registrars, consultants, and sonographers and the proximity of jobs with London-weighted salaries makes hiring much more difficult. Midwives are dedicated but proximity to London poses a challenge, e.g. Hillingdon offering an addition £1,200 salary.

Wexham Park is experiencing a significant increase in cultural diversity, and both sites are experiencing an increase in women with complex and comorbid conditions.

The suggestions made by East Berks for the STP plans included:

- Sharing community services across geographical areas, and sharing staff and facilities which would especially help with facilitating an increase in home births
- The AHSN standardising emergency and rare conditions management

3. Options for Increasing Capacity

Four options were proposed:

1 Each provider makes arrangements to meet the capacity need in their own catchment
2 The whole system plans to develop one 'super' maternity centre which is capable of delivering increased capacity at scale
3 There is a plan to increase the provision for Midwife Led Units in the community and increase the rate of home births
4 There is an option to look at a joint approach to support all units

It was noted that a description of a 'super centre' had not been provided and that therefore groups had made assumptions about what this could involve.

- The attendees were asked to consider the options from the following perspectives:
  The User Perspective
  Considering choice, access, experience, quality and safety
- **The Workforce Perspective**
  Considering recruitment, clinical teams, training and development
- **The Provider Perspective**
  Considering sustainability, accessibility and quality.

The Forum members identified the following Opportunities and risks associated with the options

3.1 From the User perspective

- Women want confidence that they will be free to make a choice of where to give birth and that they can expect their choice to be available to them unless it subsequently becomes unsafe for them or their baby. There was concern that especially for low risk women their choice could be the first to be compromised where there was capacity pressure in a Unit.
- Improved education is very important. It was noted that MLUs and home birth units have a low uptake, and questions were posed about whether this was due to how women are informed about their choices and by whom. It was felt that the safety of the MLUs was not well known and that in some cases midwives may inadvertently put women off accessing these options
- With regard to the home birth rate, questions were asked about the extent to which this was influenced by staff shortages. It was suggested that providers should maintain a dedicated team for home births but there were options for this to be shared across providers and a wider geography
- With regard to the super centre option, there was an understanding that this would be a 'specialist' centre and on that basis, there was an expectation of high quality of care, state of the art technology and a recognition that its size should mean it could offer more flexibility. However, whilst it was agreed that women would be willing to travel for specialist care, this would only impact the minority of women. For the majority, a local service with easy transport would be more important and so the super centre option was not considered viable
- Consistency is important. This would mean the various providers in the Thames Valley, and some on the borders, agreeing to work to the same protocols so that if a woman had to be transferred to a different unit at a late stage, she could expect to receive care in the way it had been described to her at the original Unit. It was noted that different processes in different Units are a cause of stress for women who have been transferred. Consistency would support the network options
- Consistency of protocol would require improved IT infrastructure across the patch
- Not detracting from the consistency issues, the preference is for a relationship between the woman and her midwife to be sustained. Women need to feel more confident to make a choice and it was agreed that her relationship with her midwifery teams will facilitate this
- Antenatal care needs to be coordinated locally so that it is available to women close to their home, regardless of where they give birth
- What 'choice' means is not clear to the public. Should they expect to be able to make a full choice or to choose from the options on an individual provider's 'menu'? What are the legalities of the latter?
- It was noted that it would be important to have user involvement embedded in any discussions about change of provision

3.2 From the Workforce perspective

- There was a sense that the super centre made some sense but it was not supported from the workforce perspective. It was felt that recruitment would be difficult as people prefer working

in local services and whilst it could reduce training variation, there was a risk it would become too big and lose personality

- Economies of scale are a significant benefit of supercentres which could include reduced back room costs. They have the benefit of a larger workforce that can work more flexibly and would be good for high risk women.
- A super centre would offer the potential of a hub and spoke model
- From the workforce perspective, local solutions to local capacity issues were preferred as it was felt that this would allow for better management of peaks and troughs and would help to grow teams
- Developing local teams would give rise to an opportunity to build a number of centres of excellence with different providers specialising in different clinical areas
- Local development will require facility development and finance support will be key
- In respect of the community model, it was felt that there is no need for any additional freestanding MLUs but the system could use more AMUs which were considered to be better for both women and staff
- There is a need to change the culture of obstetricians and midwives if women are to be encouraged to use FMUs
- In the community model, there is a need for fluidity of staffing to enable them to work from different centres

Suggestions from the workforce perspective:

- Assessing the role of the GP and what they are able to take on from a local provision of service point of view
- The development of ongoing training and development of senior positions
- The creation of new roles such as physician's assistant, and how these roles need to be monitored
- It was noted that we may benefit from recruiting with a wider net in mind; recruiting across local areas to correct under recruitment.
- Closer collaboration with paramedics as they are so vital to the maternity service.
- We need to consider the influence of the bursary.
- We also need to consider the working patterns of Generation X
- It was noted that it may be worth considering which patch has the happiest midwives, and following examples from those patches.
- It was noted that GPs do want to be involved in maternity services.

3.3 From the Provider perspective

- Supercentres don't work well when the geographical spread of the patch is large and would lead to access and travel issues for women as well as potentially restricting choice
- The supercentre could have a negative impact on other units, particularly with regard to recruitment
- It was recognised that some local response to local capacity demand is required though it was stressed that this will need financial investment

- The tariff will become a significant issue if all the units tip over 6,000 births and questions were asked about what NHS England could do about this
- The local response option will need a flexible workforce spread across the wider geography and able to utilise local services in the most effective way
- There was strong support for the collaboration option though it was noted that the tariff issues would also apply to this model
- The collaborative model offered opportunities to work together with central strategic co-ordination leading on high impact issues such as recruitment across the patch, finance (to challenge the tariff), strategic planning and the development of standardised protocols and pathways
- It was felt that the collaborative model could facilitate a shared team for home births
- Within a collaborative model, there would be an opportunity to share specialists
- It was agreed that additional FMUs will not bridge the capacity gap but there would be benefit in looking at AMU expansion
- It was noted that resilience needs to be addressed and that managing adverse events/peak and troughs needs firm plans in place
- It was noted that FMUs don't just manage deliveries; they provide classes and information services, so cost per service must be considered. Uptake is low with FMUs, and there should be some investigation into why this is the case; women tend to choose the safest option (considered to be obstetric led) at the start of their pregnancy when they have less information; as the pregnancy continues and more information is available, women are more likely to choose other options.

4. Conclusions from the Maternity stakeholder event:

The following conclusions were agreed:

4.1 It was noted that whilst the focus of this event was on the capacity for deliveries, maternity services should be commissioned as a whole pathway and antenatal services should be delivered as close to home as possible and start as early as possible in the pregnancy to empower women to make appropriate choices for themselves

4.2 Whilst the model of a super centre offers some benefits, it was not felt to be the solution in this case and there was little support for it from any perspective. In particular, there was concern regarding increased travel requirements and also the potentially negative impact on recruitment for the 'spoke' Units

4.3 The FMUs have very low activity rates and it was suggested that more work is undertaken to understand the cause for this. Currently it is not clear whether women make an informed choice not to use them or whether the low numbers are a result of how the choice is communicated to women.

4.4 Currently, given the low levels of activity, there was no support to increase the numbers of FMUs. More work is required to identify the services which FMUs support and facilitate to understand the whole scale and cost of these units.

4.5 It was agreed that AMUs are perceived to be a good choice from the perspectives of both women and staff and that increasing the number would be an effective way of increasing capacity providing building space and finance was available

4.6 Home births have a low level of uptake and it was suggested that work is also undertaken to understand the cause for this. It is not clear whether women make an informed choice not to give birth at home, whether low numbers are a result of how the choice is communicated to women or how often the option is withdrawn due to staff shortages. It would be helpful to know in order to plan future services.

4.7 There was a sense, from each of the perspectives, that some level of local solution is required to address the local capacity issues but that this would not be feasible without the provision of capital monies. All providers said that this would be problematic and that it should be considered on Thames Valley wide basis.

4.8 There is a concern about the tariff and the impact of exceeding 6,000 births. Whilst the costs of going over 6,000 can be calculated, it is not known at what point the costs become break even and some modelling and/or benchmarking should be undertaken to understand this in more detail to enable robust planning and to inform further discussions.

4.9 Whilst there was agreement that there would be local resolution of capacity issues, there was strong support for a collaborative model where providers and commissioners would work together, across Thames Valley, to address cross cutting high impact issues. This model would require central strategic co-ordination.

4.10 One of the issues raised concerned consistency of service so that women and/or staff moving between different provider services, could feel confident that the pathways and protocols would be the same. This should be addressed within the collaborative working arrangement.

4.11 Recruitment and retention was cited as a problem by all providers and it was agreed that within the collaborative arrangement, there would be an opportunity to work together to undertake recruitment and offer training and development opportunities across the Thames Valley. There would also be the potential to review new roles eg physician's assistant. The collective recruitment could bring additional benefits in providing a flexible workforce.

4.12 It was agreed that another opportunity for the collaborative would be to identify whether there would be value in individual providers developing an excellence in a particular element of maternity service

4.13 The collaborative arrangement offers the opportunity to establish a shared team for home births (dependent on the findings of the review of women's choices regarding home births)

4.14 It was agreed that more could be done to maximise the potential of other clinicians in the maternity pathway including paramedics. In particular, it was agreed that GPs had expressed an interest in having a great involvement in maternity care for their population and more work was needed to understand what this could mean and what training would be required.