NHS
Northern England
Clinical Networks

The Path to Excellence
South Tyneside and Sunderland NHS Partnership

The purpose of this paper is to summarise the conclusions from a meeting of the Northern England Maternity Clinical Network held on 11th September 2017 at Evolve Business Centre, Houghton-le-Spring, at which the maternity components of the 'Path to Excellence' transformation proposals were discussed.

Background

The following attended the network meeting on September 11th, and presented a summary of the 'Path to Excellence' proposals to the group:

- Patrick Garner, Programme Manager - South Tyneside and Sunderland Healthcare Group
- Derek Curry, Head of Midwifery, South Tyneside District Hospital
- Sheila Ford, Head of Midwifery, Sunderland Royal Hospital

The network meeting was attended by medical clinicians, senior midwives and commissioners from around the North East and North Cumbria

Summaries of the discussions

The main question asked of the Maternity Clinical Network was whether or not freestanding midwifery units (FMUs) are a safe option in which healthy mothers with uncomplicated pregnancies can give birth, but the views of the group were also sought (or expressed) about various other issues such as arrangements for transfer of women with complications during labour, the sustainability of FMUs, compliance with 'Better Births', workforce factors, and capturing relevant local experience from other providers who have been (or are going) through a similar process.

<u>Safety of a Freestanding Midwifery Unit at the South Tyneside District General Hospital site</u>

The discussion around the safety of FMUs began with an acknowledgement of the conclusions from the 'Birthplace' research project, a large, multicentre study, which concluded that healthy women with uncomplicated pregnancies opting for a birth in either a freestanding (or alongside) midwifery unit, as compared with an 'Obstetric' unit, have a higher chance of a spontaneous vertex birth, as well as a lower chance of either an instrumental assisted birth and / or an intrapartum Caesarean section – without any increase in the risks of either the baby not surviving the birth and / or experiencing significant illness as a result of the birth process. Transfers from non-obstetric unit settings were reported to be more frequent for women in their first pregnancy (about 36-45%) than for those who had given birth before (9-13%).

The network group felt that it was entirely reasonable to believe that the findings of the Birthplace study are directly transferable to the anticipated outcomes of women choosing to give birth in a potential FMU at South Tyneside (in Option 1) – on the basis that the demographics of the local population, as well as the transfer times to the nearest obstetric unit are within the range of general characteristics associated with the large number of FMUs surveyed for the Birthplace study.

Local transfer issues

It must be acknowledged, however, that the safety of such units is dependent upon there being robust systems in place for the emergency transfers of women to the nearest Obstetric unit when complications arise. In order for the findings of the Birthplace study to be transferrable to a potential FMU at South Tyneside, the arrangements for transfer – and the response times from NEAS – would have to be broadly comparable with those in place for other FMUs across the country.

Sustainability issues

The group discussed several issues in relation to the sustainability of FMUs

The group acknowledged that local and national experience with FMUs has been that many 'low risk' pregnant women, who are eligible to give birth in a FMU, choose instead to have their baby in either an alongside MLU and / or an obstetric unit (even if it means travelling greater distances to do so). It's presumed that one of the main reasons for the apparent unwillingness to opt for a FMU is a concern about the need for transfer to the nearest obstetric unit, should complications occur during labour. Hence, the numbers of women giving birth at FMUs is often much lower than anticipated from the size of the local population – which is likely to be one of the main reasons why several such units across the country and in our region have either closed or are under threat of closure.

The network group noted, however, that it's only recently that maternity healthcare providers have had the evidence they need to (a) assure women about the safety of opting to give birth in a FMU (or alongside MLU), as well as (b) promote the significant benefits in doing so. It's possible that a greater evidence-based confidence amongst midwives (about the safety and benefits of MLUs) when counselling women about place of birth might lead to a greater take up of this option. There was a feeling amongst the group that the developing Maternity Voice Partnerships across the region might have a role to play in promoting the benefits of midwife-led intrapartum care for healthy women.

Moreover, not all FMUs experience a substantial reduction in the numbers of births over time – and it's noticeable (from local experience) that those with higher levels of activity (or the least reduction in numbers of birth) tend to be characterised by the on-site provision of other aspects of antenatal and postnatal maternity care, such that they become a busy, vibrant focus of maternity care in the local community.

There was mention during the discussions of the oft quoted assertion that FMUs need about 300 women giving birth within them every year in order for them to be 'viable'. The group acknowledged, however, that this statement refers primarily to an analysis of the finances of running a FMU – looking at the fixed costs of providing such a facility, and comparing this with the level of remuneration under the present maternity payments system. There are, however, also concerns about the maintenance of staff skillsets when working purely in a clinical setting with relatively low levels of activity.

The group noted that many FMUs across the UK have fewer than 300 births p.a. – and that the majority of these units submitted data to the 'Birthplace' study, meaning that lower levels of activity are not necessarily an insurmountable barrier to providing high quality care.

There was a discussion about a number of steps that can be taken to provide staff with appropriate experience, such as rotation to neighbouring and busier units.

As regards the financial sustainability of a FMU, there was a suggestion at the meeting that this needs to be looked at in the context of an overall financial analysis for a maternity service (and / or trust – or even a healthcare system) – in which there will always be elements of a service that are more financially challenging than others.

The group concluded that there is no single threshold number for the numbers of birth that are needed at a midwife-led unit to make it viable, but that individual decisions need to be taken considering a wide range of issues

Workforce issues

The importance of staff engagement was emphasised on several occasions during the discussions, as was the need to (i) win over the 'hearts and minds' of staff in order for any substantial change in service design to be successful, and (ii) avoid making any assumptions in relation to the retention of staff in a changed service model – all of which was readily acknowledged from the 'Path to Excellence' team, who confirmed that these principles have been at the core of their work.

A suggestion was made that it might be helpful to survey the workforce (midwives, medical staff and others) as a means of (a) assessing staff attitudes and the numbers of midwives who might want (or be prepared) to work in either a busier maternity unit and / or a FMU, as well as (b) encouraging a sense of inclusiveness with regards to the process of determining the optimal service model.

Learning from the experience of others

Experience with FMUs in the region has been variable. Some – such as the unit at the Friarage in Northallerton - have been very successful in terms of the numbers of women opting for them as their preferred place of birth, whereas others have seen levels of activity decrease to a point where either units have shut, or the sustainability of a service is currently being questioned. The importance of making such units an active hub for maternity care was emphasised as a means of building confidence in the service amongst the staff and local population. The South Tyneside and Sunderland senior leadership team leaders confirmed that have already been in touch with colleagues from across the area to seek out areas of good practice.

Training issues

The group noted that South Tyneside Hospital are not currently approved for the training of junior medical staff in Obstetrics and Gynaecology – and any proposal that included an intention to re-establish training would mean having to go through a process of reapplication for accreditation.

Summary

There was a general agreement amongst those present that with appropriate assessment of women and adequate transport and backup, FMUs are a safe and high quality birth option for healthy women with uncomplicated pregnancies; a conclusion that is based on high quality evidence – albeit with a proviso that the general characteristics of such a unit are not dissimilar to those in place across the country, and that transfer times are not significantly different from the national average.

The group acknowledged the difficulties with sustainability of such units, but there was agreement that much can be done to overcome any potential issues such as maintenance of skills amongst the workforce, and the numbers of women choosing a FMU as their preferred birth option.