Attachment 3

Changes to delivery services in the Community Maternity Units

1. Current services

Midwife led care has been well established in CMUs since the inception of the community maternity units in 2004. Both CMUs are busy services providing a wide range of maternity care to all women in each locality with around 5000 non birth contacts in each year. These services offer high quality local outpatient and day care which is described in further detail in the rest of this section.

**Midwifery Teams:** Midwives work within geographical teams providing antenatal and postnatal care to a defined caseload of women. They provide first point of contact for early booking to the maternity services and provide continuity of carer with a maximum of three midwives for scheduled visits. CMU midwives are highly skilled, working autonomously but within a multidisciplinary context across antenatal, intrapartum and postnatal care. They maintain these skills by frequent in-house updates and attendance at Scottish Maternity Multidisciplinary Development Programme (SMMDP) courses.

**Antenatal Care:** Midwives are the first point of contact for all women as part of Keeping Childbirth Natural and Dynamic (KCND) care pathway they provide:-

- midwife led care to women on the low risk pathway
- shared care to women with an obstetrician as lead clinician
- parent education classes for women and their partners
- breast feeding support and workshops
- Preparation for labour and birth
- a home birth service for those women who meet the evidence based criteria
- care for vulnerable women supported by the Special Needs in Pregnancy Service (SNIPS)
- Liaise with other multidisciplinary agencies e.g. GPs, health visitors, social work, perinatal mental health and child protection unit
- day care assessment and early pregnancy assessment
- support high risk obstetric clinics
- Fulfil the health improvement imperatives of the public health agenda e.g. alcohol brief intervention, smoke free and carbon monoxide (CO) monitoring, breast feeding, cot death, referral to other agencies

**Postnatal care:** Midwives provide:-

- postnatal care to mother and baby
- detailed examination of the newborn and newborn blood spot screening
- infant feeding advice and support
- Management of jaundice within West of Scotland guidelines
- Liaison with GP and health visitor and other agencies as required
- formal handover to health visitor at day 10 or when appropriate

The Units both currently provide intrapartum services for women. These include providing:-

- telephone triage advice in early labour to support timely and appropriate admission to the CMU or Labour ward
- 1 to 1 care in labour in a freestanding midwife led birthing suite environment
- low risk care, including water birth and support for women using alternative therapies for labour and birth. Enabling women to be mobile with minimal interventions. This reduces the risk of unnecessary medical intervention and also enhances the woman’s birth experience
Importantly all midwives must maintain the required knowledge and skills in dealing with obstetric and neonatal emergencies, keeping woman and baby stable until ambulance transfer to a consultant led obstetric or neonatal unit can be arranged as required.

Numbers of women opting to use those delivery services have continued to decline from the planned level of around 200 for each Unit. During 2015/16, there were only 17 deliveries in IRH and 43 at VOL. The overwhelming majority of women choose to have their ante and post natal care in the Units but opt for delivery in hospital, as the table below sets out:-

Births to Greater Glasgow and Clyde residents in Inverclyde and VOL Catchments

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</thead>
<tbody>
<tr>
<td>inverclyde HSCP Residents</td>
<td>835</td>
<td>808</td>
<td>789</td>
<td>776</td>
<td>765</td>
<td>738</td>
<td>711</td>
<td>685</td>
</tr>
<tr>
<td>delivered at IRH</td>
<td>94</td>
<td>107</td>
<td>67</td>
<td>63</td>
<td>42</td>
<td>34</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>% at IRH</td>
<td>11%</td>
<td>13%</td>
<td>8%</td>
<td>8%</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>vale of leven HSCP Residents</td>
<td>822</td>
<td>829</td>
<td>745</td>
<td>836</td>
<td>761</td>
<td>695</td>
<td>740</td>
<td>679</td>
</tr>
<tr>
<td>delivered at VOL</td>
<td>96</td>
<td>112</td>
<td>81</td>
<td>103</td>
<td>93</td>
<td>77</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>% at VOL</td>
<td>12%</td>
<td>14%</td>
<td>11%</td>
<td>12%</td>
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<td>11%</td>
<td>4%</td>
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Total Deliveries at Inverclyde Royal Hospital and Vale of Leven Hospital

<table>
<thead>
<tr>
<th>total deliveries</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17 (to June)</th>
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<tbody>
<tr>
<td>Inverclyde Royal Hospital</td>
<td>27</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Vale of Leven</td>
<td>39</td>
<td>43</td>
<td>7</td>
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</tbody>
</table>

Following the previous public consultation the Board agreed to undertake an extensive programme of communication to try to increase the number of women opting to use the delivery services. Midwifery staff at both CMU’s have actively promoted birth within the units and this has included:

- Discussion with all women at booking visit offering information around choice of place of birth which is reinforced with a patient information leaflet
- Option to leave decision about place of birth until later on in the pregnancy
- Leaflet distribution on services provided to local libraries, GP & Dental Practices, commercial premises and leisure facilities
- Visits to local school nurseries and mother and toddler groups
- Open days within the unit
- Stall at local supermarkets
- Variety of features in Greenock Telegraph

The Vale Vision committed us to continue the delivery service until at least 2011 and also included a commitment to retain the service for three years to try to increase numbers. As the table above illustrates those efforts have not succeeded.
2. Case for Change and Proposed Service

2.1. The proposal is to retain all ambulatory services at the CMUs with midwife led intrapartum care in RAH, PRMH and the QEUH or at home. The birthing facilities in the Vale and the IRH CMU’s will cease to operate.

- The RAH CMU has approximately 300 births per year and has the provision to expand from 3 postnatal beds and 4 birthing rooms up to 6 postnatal beds to meet the transfer of birth activity from IRH and Vale CMU’s.

- Currently there is a dedicated home birth team which covers Glasgow and this will be extended to a GGC home birth team. Again there is an evidenced based criteria for home birth. There have been no recruitment issues for staff in the homebirth team and as this is their only function they are able to maintain their intrapartum care skills. In parallel to this work we will review arrangements for midwifery led births in our QEUH and PRMH sites to ensure informed choice and that all pregnant women we care for have full range of care and birth options available to them.

The reasons we are proposing changes are set out in the rest of this section.

2.2. The demographics of the Maternity population has changed and there are fewer women who meet low risk criteria. The reduction in numbers of women who choose to give birth in the CMU’s reinforces the clinical and service challenges in sustaining safe CMU birth facilities. Challenges include staff recruitment, retention and skill maintenance and there have been adverse clinical incidents.

2.3. When complications arise ensuring safe and prompt transfer of ill neonates or women in labour to the consultant units can be problematic. The Vale and IRH CMUs are free standing. If there is a requirement for medical/anaesthetic or neonatal assistance in the intrapartum and immediate postnatal period, the mum and / baby require to be transferred to the Consultant led unit at RAH. This may delay any necessary treatment and ultimately can affect care and influence morbidity. Some of the main reasons for transfer will include the requirement for epidural anaesthesia, delay in either the first or second stage of labour, concerns over fetal heart rate in labour, concerns over retained placenta requiring surgery, repair of an extensive perineal tear and transfer of the neonate for neonatal life support. These reasons also pertain to the homebirth service. All of these issues and the transfer rate are discussed with the woman at booking when she makes her choice over place of birth. Transfers do occur with our alongside CMU but the travel distance is minimal and some transfers can be avoided as medical staff are on site and can attend immediately to the CMU if required.

2.4. The Ombudsman’s report following an adverse event in the Vale of Leven CMU in October 2013 (investigation report September 2015) evidenced this. A similar case in NHS Tayside is currently the subject of an FAI which should report in the autumn. The alternative services available at the RAH and QEUH enable women to opt for a midwife led birth. Importantly any woman who fits the criteria for a CMU birth can choose to have her baby at home.

2.5. Maintenance of intrapartum skills is challenging given the low number of births at IRH and Vale CMU’s. Up to and including June this calendar year, there have been a total of 5 births at IRH and 13 births at the VOL and no home births. Given the low numbers of CMU and no home births the midwives have to rotate into the RAH CMU to maintain intrapartum competence and skills. The IRH and VoL CMU has an on-call system for out of hour’s births.
2.6. The challenge of maintaining an on call system over the past five years has had a heavy toll on midwives within the CMU, and is becoming more and more difficult to sustain. This is due to a number of factors which includes the age profile of midwives, difficulty in recruiting midwives, placing a greater burden on the existing staff and an increased on-call commitment. It is also becoming difficult to recruit to the CMU's as midwives need to live within 50 minutes of the units in order to respond to a woman in labour.

2.7. Staffing issues the main compelling arguments for change are based on staffing issues – we are finding it difficult to recruit to the CMU's as you need experienced staff who live close enough to attend when a woman presents in labour out of hours (including weekends). Also due to the falling number of births, midwives are at risk of becoming deskillled in intrapartum care and must complete a rotational programme to the CMU at RAH. This rotation does affect the continuity of care for women in the antenatal and postnatal period and the benefits this provides. These issues all ultimately have an impact on the quality of care that women receive.

3. National Review of Maternity and Neonatal Care A national review of maternity and neonatal services was launched in February 2015 and is due to report in the summer of 2016. The Review is focused on creating a refreshed model of care and approach to maternity and neonatal services and it aims to examine choice, quality and safety of maternity and neonatal services in light of current evidence and best practice, in consultation with the workforce, NHS Boards and service users. The Review Group has just concluded and extensive programme of engagement with stakeholders and has identified a number of themes which will be reflected in the final Report.

- Continuity of care and carer
- Relationship-based, personalised care
- The remote and rural context
- Workforce – including education, skills, recruitment and age profile
- A multidisciplinary team approach and clear pathways for referral
- Supporting and keeping mums, babies and families together as much as possible

The Group have also highlighted the importance of facilitating normal births and normality, and addressing health inequalities to ensure alignment with the review we will:-

- Continue to work with the Chief Medical and Nursing Officers to deliver the national priorities and ensure the promotion of midwife led care and birth facilities in our maternity units;
- draw on the National review material during our local engagement on the CMU delivery services will aim to time the reporting of the outcome of our engagement to the Board for decision with the publication of the National Review Report so that our decisions are made in that context.

4. Proposed Approach to Engagement

There has been extensive public engagement and formal public consultation on these changes and the proposals have raised limited concerns from the women who are likely to use the services. Our proposal is to have re engagement to ensure all key stakeholders are aware of the proposal and have the opportunity to offer their views. The proposed approach to this re engagement is to establish a two stakeholder reference groups, one for each service, which will with us on the engagement process which will include:-
refreshing the outputs from previous public engagement,
local workshops enable stakeholders to hear and explore the proposal. This workshop will include explaining the issues with the option of retaining the status quo and enabling stakeholders to challenge our appraisal of those issues;
A range of communication resources and a detailed communications plan;
Ensuring the engagement enables all patient perspectives to be on access or other issues
Advise on the best means of engaging with those affected and local communities,
public engagement events including outreach to mums and toddler groups and parent support groups.

The focus of the engagement will be on potential patients but will also enable wider local interest to express their views.
The SRGs will include:-

- Current or recent patients of the CMU
- Representation from local Health and Social Care Users Forum or equivalent
- Identified public representatives of each HSCP

This approach to engagement will enable the Board to consider the local patient views of these proposed changes alongside the outcome of the national review of maternity services in reaching a decision.