Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 14 March 2018

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Thursday, 22 March 2018**
Time: **2.00 pm**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Joint Health Overview and Scrutiny Committee

Shropshire	**Telford and Wrekin**
Cllr Karen Calder (Co-Chair)	Cllr Andy Burford (Co-Chair)
Madge Shineton	Cllr Stephen Burrell
KiddCllr Madge Shineton	Cllr Hilda Rhodes
David Beechey (Co-optee)	Carolyn Henniker (Co-optee)
Ian Hulme (Co-optee)	Hilary Knight (Co-optee)
Mandy Thorn (Co-optee)	Dag Saunders (Co-optee)

Your Officers are:

Amanda Holyoak Scrutiny Committee Officer
Shropshire Council
01743 252718 amanda.holyoak@shropshire.gov.uk

Jessica Tangye Senior Democratic and Scrutiny Services Officer
Telford and Wrekin Council
01952 382061 jessica.tangye@telford.gov.uk

AGENDA

1 Apologies for Absence

2 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matters in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes

To note that the minutes of the meeting held on 3 March 2018 will be presented to the next meeting of the Committee.

4 Shropshire, Telford and Wrekin Midwife Led Unit Service Review (Pages 1 - 78)

To receive and consider information on the Shropshire and Telford and Wrekin Midwife Led Unit Service Review, and particularly

The Current Position
Impact Assessment
Proposed Service Model
Consultation document and Consultation Plan

The following will be present at the meeting:

Fiona Ellis, Programme Manager, Shropshire and Telford and Wrekin Local Maternity System
Adam Gornall, Clinical Director – Women & Children, Shrewsbury & Telford NHS Hospital Trust (SaTH)
Dr Jessika Sokolov – Clinical Lead, Shropshire Clinical Commissioning Group
Sarah Jamieson – Head of Midwifery – SaTH

5 Co-Chair's Update

Shropshire , Telford and Wrekin Midwife Led Unit (MLU) Review : Proposed Service model

Dr Jessica Sokolov: Clinical Director Women and Children Services and Deputy Chair Shropshire CCG

Joint HOSC
March 22 2018

Update: why was the review necessary?

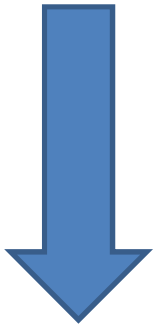
- Public concerns at SCCG board end of 2016
- SaTH concerns re : staffing model and funding model
- Reminder of current provision

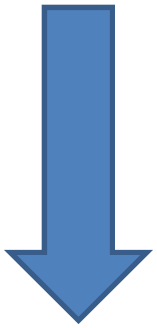
Designing the service: The process

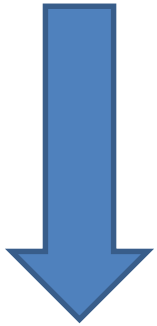
Phase 1
Analysing existing information

Phase 2
Gathering new information

Phase 3
Co-design workshops







Proposed Service Model

Proposed service model: Pre-pregnancy

Outside the direct scope of the review, but included for completeness and will be passed on to the Local Maternity System for action:

- Improved information about the importance of good health during pregnancy
- Improved information sharing between professionals
- Services to improve the health of women (mental and physical) before pregnancy

Proposed service model: Pregnancy

- At least 5 maternity hubs across the county which will be available for at least 12 hours a day for planned midwifery led care.

- It is proposed that there will be at least one maternity hub in at least each of the following areas: Telford, Shrewsbury, Bridgnorth, Ludlow, Oswestry.

- Access to advice and support from a midwife 24/7. This will include an excellent triage service available 24/7 for women to ring when they think they're in labour to help to ensure that they get to their chosen place of birth on time.

Proposed service model: Pregnancy

It is proposed that the same types of service are available at each maternity hub, including:

- Antenatal care from a midwife and support from women's services assistants
- Planned antenatal appointments with an obstetrician
- Scanning and fetal monitoring
- Antenatal day assessment, including CTG (where baby's heart rate and movements are monitored)
- Support with emotional wellbeing and mental health
- Support with long term conditions during pregnancy
- Healthy lifestyle services including smoking cessation and weight management services
- Information and advice about pregnancy and parenthood
- Information and advice about birth options
- Peer support

Proposed service model: Pregnancy

Other features of this part of the model include:

- The development of a ‘becoming a family’ plan
- Receive care that plans for women to give birth in a midwife led setting
- Women get to know the place where they plan to give birth and meet the midwives who are likely to deliver their baby
- Staff work within a team with a mix of skills
- Women will not need to make a decision about where they plan to give birth until later on in pregnancy
- Women have a say and feel fully involved in making decisions about their care, including when unexpected things happen
- Women and staff have up to date information electronically
- Women and staff have a say in decisions about the service, including service improvements.

Proposed service model: Birth

- Full range of birth settings to choose from (Consultant led unit, Alongside Midwife Led Unit, Freestanding Midwife Led Unit and Home Birth).

- Births within Shropshire to be available at:
    - Consultant led Unit at Princess Royal Hospital
    - Alongside midwife led unit at Princess Royal Hospital
    - Freestanding midwife led unit at Royal Shrewsbury Hospital
    - Home Birth

- The choice of birth settings will include places over the Shropshire border, which may be more convenient for those living on the edges of the county.

Proposed service model: Birth

Other features of this part of the model include:

- The MLUs in Telford and Shrewsbury may also act as the maternity hubs for antenatal and postnatal care.

- Women have a say and feel fully involved in making decisions about their care, including when unexpected things happen.

- Women and staff have up to date information electronically.

- Women and staff have a say in decisions about the service, including service improvements.

Proposed service model: Birth

This proposed model is designed to increase the number of midwife-led births by:

- Over time, improving the health of women during pregnancy.
- Changing pathways in antenatal care so that all women receive care that plans for a midwife led birth, unless this won't be safe for the woman or her baby, or she chooses consultant led care for another reason.
- Enabling women during pregnancy to get familiar with the midwife led units and the staff who work there.
- Enabling women to make a decision about their preferred place of birth later in pregnancy.
- Moving the alongside midwifery led unit closer to the consultant led unit in order for a different level of risk to be safely managed.

Proposed service model: Postnatal

- Community midwives and women's support assistants available 24/7.

- At least 5 maternity hubs across the county which will be available for at least 12 hours a day for planned midwifery led care.

- It is proposed that there will be at least one maternity hub in at least each of the following areas: Telford, Shrewsbury, Bridgnorth, Ludlow, Oswestry.

- Inpatient postnatal stay available on Princess Royal Hospital postnatal ward for women who need it.

Proposed service model: Postnatal

It is proposed that the same types of service are available at each maternity hub, including:

- Postnatal care from a midwife
- Support and advice from women's services assistants with regards to baby care
- Newborn checks and screening
- Drop-in service or planned access during a 12 hour period
- A space for women and their families to reflect on the birth experience
- Support with emotional wellbeing and mental health
- Support with confidence building and bonding
- Support with feeding
- Support with long term conditions postnatally
- Healthy lifestyle services
- Information and advice about parenthood including postnatal groups, infant feeding, baby care and life skills such as budgeting and cooking
- Peer support

Proposed service model: Postnatal

Other features of this part of the model include:

- Staff work within a team with a mix of skills.
- Women have a say and feel fully involved in making decisions about their care, including when unexpected things happen.
- Women and staff have up to date information electronically.
- Women and staff have a say in decisions about the service, including service improvements.

Next steps for the review

Proposed model approved to progress to consultation by Shropshire CCG and Telford and Wrekin CCG following completion of the NHSE Assurance process.

HOSC will receive results of consultation.

Dr Jessica Sokolov
Clinical Director Women and Children Services and Deputy Chair Shropshire CCG

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Meeting	Shropshire, Telford and Wrekin Joint Health Overview Scrutiny Committee Thursday 22nd March 2018
Title of the report:	Shropshire, Telford and Wrekin Midwife Led Unit Review
Author of the report:	Fiona Ellis – Programme Manager; Shropshire, Telford and Wrekin Local Maternity System
Presenter:	Dr Jessica Sokolov – Deputy Clinical Chair, Shropshire CCG

Purpose of the report:

To inform Joint HOSC of the findings of the Shropshire, Telford and Wrekin Midwife Led Unit Review and to present the proposed model for approval.

Key issues or points to note:

The review findings suggest that:

- The current model is not clinically sustainable and that the current staffing levels and skill mix are not appropriate for the demand. Improvements to staffing levels and skill mix need to be made as well as addressing issues around staff wellbeing.
- The current model is safe, but currently inequitable. Further consideration needs to be given to how the performance and quality of midwifery led care can be further improved to achieve better outcomes for women and their families. Once published, the findings of the wider reviews currently taking place will also need to be taken account of (i.e. the Secretary of State Review, and Royal College Obstetricians and Gynaecologists Review).
- Improvements to rural access could be made with regards to ensuring consistency in community provision across the county. Consideration also needs to be given with regards to whether the long journey times can be improved for the women needing to access consultant led care, but live a distance from Princess Royal Hospital.
- The driver for this review should be how to get services working as efficiently as possible, to get the best use of funds, staff and assets with the principle objectives being clinical sustainability, equity of access and improved outcomes.

A new service model is proposed that seeks to improve clinical and financial sustainability of midwifery led care as well as improving access to services and outcomes for women and their families.

Actions required by HOSC:

It is recommended that HOSC:

- Note the review findings and proposed service model.

Shropshire, Telford and Wrekin Midwife Led Unit Review

1. Executive Summary and Actions Required

The review findings are that:

(i) The current model is not clinically sustainable. The current staffing levels and skill mix are not appropriate for the demand. Improvements to staffing levels and skill mix need to be made as well as addressing issues around staff wellbeing.
(ii) The current model is safe, but further consideration needs to be given to how the performance and quality of midwifery led care can be further improved to achieve better outcomes for women and their families. Once published, the findings of the wider reviews (i.e. the Secretary of State Review, and Royal College Obstetricians and Gynaecologists Review) currently taking place will also need to be taken account of.
(iii) Improvements to rural access can be achieved by ensuring consistency in community provision across the county. Consideration also needs to be given with regards to whether the long journey times can be improved for the women needing to access consultant led care, who have significant travel times to Princess Royal Hospital.
(iv) The driver for this review has been how to get the services working as efficiently as possible, to get best use of funds, staff and assets with the principle objectives being clinical sustainability, right care, and best value. The CCG will not pay above tariff for maternity services and therefore should support efforts to remodel services that will drive cost out for SATH whilst improving clinical sustainability, equity of access, and improved outcomes.

1.1. A new service model is proposed that seeks to improve clinical and financial sustainability of midwifery led care as well as improving access to services and outcomes for women and their families.

1.2. Shropshire, Telford and Wrekin Joint Health Overview Scrutiny Committee are asked to note the findings of the midwife led unit service review.

2. Introduction

2.1. Shropshire, Telford and Wrekin maternity services are provided by Shrewsbury and Telford Hospitals NHS Trust (SaTH). There are five Midwife Led Units (MLUs) that provide antenatal, birth and postnatal care in Shrewsbury, Ludlow, Oswestry, Bridgnorth and Wrekin. Wrekin is on the same site as the Consultant Led Unit at Princess Royal Hospital in Telford. In addition there are two Community Hubs at Market Drayton and Whitchurch where antenatal, home birth and postnatal care is provided.

2.2. The MLU operating model has remained consistent over the past thirty years undertaking all antenatal bookings and both high and low risk antenatal care for the Consultant Unit. The MLUs also deliver antenatal and postnatal community care, postnatal inpatient care as well as low risk births.

2.3. Shrewsbury and Telford Hospital NHS Trust have raised concerns regarding the sustainability of the current MLU model and in response, Shropshire Clinical Commissioning Group (CCG) has led a comprehensive service review on behalf of both Shropshire CCG and Telford and Wrekin CCG.

2.4. The purpose of Shropshire, Telford and Wrekin midwife-led unit service review is to review:

- whether or not the clinical model of delivery currently in place in Shropshire, Telford and Wrekin is clinically sustainable
- the safety of, and the clinical outcomes from, the current model and to establish whether or not these are acceptable for Shropshire, Telford and Wrekin patients
- any quality concerns relating to the service and make recommendations to address these
- staffing of the units to ensure this is appropriate for the requirements of the units and that there is a clear workforce plan to support service delivery
- any concerns relating to rural access to the services and make recommendations to address these
- the financial sustainability of the five MLUs. This can only be done within a financial review of the whole of the SATH Maternity service and tariff income
- whether the current model provides value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability and make recommendations to address this where this is not the case

2.5. The terms of reference for the review state that where the review identifies issues in relation to value for money, access, safety, quality, clinical outcomes, clinical sustainability or financial sustainability, alternative models of service provision will be developed in partnership with stakeholders.

2.6. In addition to addressing the particular considerations for this review, the work also took account of the national direction for maternity services as set out in the 2016 Maternity Review Report. *Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)*[1].

2.7. The midwife led unit review was undertaken in three phases:

- Phase 1 (Analysis of existing information) considered a range of existing information from a number of different organisations.[2]
- Phase 2 (Gathering new information) included gathering detailed information from women and their families as well as professionals working in or with maternity services through a series of in-depth interviews.
- Phase 3 (Co-design workshops) involved commissioners, women and their families, staff and community members with an interest in midwifery led care discussing together what a new model of care may need to include.

2.8. The information gathered during Phase 1 and Phase 2 was used to inform discussion in the co-design workshops in Phase 3.

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[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[2] Different organisations use a variety of data definitions and collection methods. As several data sources were used to inform this report, there is slight variability in some of the figures reported.

3. Summary Findings

3.1. The findings described below relate to midwife led services. However, it should be noted that these services do not operate in isolation and are delivered within the context of maternity services as a whole. Therefore, where relevant reference is made to how other elements of maternity provision may affect/be affected by changes in midwifery led care.

3.2. *Is the clinical model of delivery currently in place in Shropshire, Telford and Wrekin clinically sustainable? Is the staffing of the units appropriate for the requirements and is there a clear workforce plan to support service delivery?*

3.3. The findings of Birthrate Plus[3] (BR+) in April 2017 suggest that an increase in staffing is required in order for the current service model to be sustainable. The BR+ report produced for SaTH maternity services suggests that an overall increase in staffing is required, but that the smaller MLUs are over-staffed for the level of activity.

3.4. BR+ states that for the MLUs and community bases, the shortfall of 13.06wte are not just midwives and a significant number can be appropriately qualified maternity support workers (MSW) assisting with postnatal care in the MLUs and community. An estimated 10.66wte could be MSWs across the total community, reducing the midwifery shortfall to 2.40wte. For the consultant-led unit a shortfall of 15.56wte was identified, of which an estimated 6.0wte could be appropriately qualified maternity support workers, reducing the midwifery shortfall in the consultant led unit to 9.56wte.

3.5. Recent increases in staff absences have increased the fragility of the service. The findings of the review suggest that the skills of existing staff aren't being utilised in the most efficient way. Women giving birth in consultant led units don't always get 1:1 care in labour, whereas women giving birth in midwife led units or at home have at least 1:1 care in labour. There are other models of care which may offer greater sustainability and need to be considered.

3.6. Staff morale is low. Whilst in general relationships within teams are good, relationships with colleagues beyond their immediate team are more fractured; and many people feel unsupported by management. Women's support assistants and midwives report that recent changes are compromising the care they are able to offer as there is not enough time during appointments and home visits. Staff are worried that 'something will be missed' as they don't have enough time with women.

3.7. Increasingly, midwives do not feel in control of their working lives. They feel frustrated and angry. Staff feel disengaged from and let down by senior managers. Midwives report that not feeling in control is impacting on their work and home lives and on their emotional wellbeing, health and happiness. Staff feel they are letting their ladies down – especially in areas where there have been MLU closures.

[3] Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making. The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birthrate Plus

3.8. **The findings suggest that the current model is not clinically sustainable and that the current staffing levels and skill mix are not appropriate for the demand. Improvements to staffing levels and skill mix need to be made as well as addressing issues around staff wellbeing.**

3.9. *Is the safety of, and are the clinical outcomes from, the current model acceptable for Shropshire, Telford and Wrekin patients? Are there any quality concerns relating to the service?*

3.10. The CCG Clinical Quality and Review processes consider the safety and clinical outcomes from the current model to be acceptable. However, the outcomes and recommendations from wider reviews will need to be considered, once published. In addition, consideration needs to be given to how the current performance around safety and clinical outcomes can be further improved, as well as how midwifery services can work with other wider services, such as those commissioned by the Local Authority to further improve longer term outcomes for women and their families.

3.11. Whilst women did not report any issues relating to quality and safety, some concerns were raised by midwives.[4] Midwives reported that changes in working practices were compromising continuity and their close relationships with women. Midwives perceive that it is becoming more difficult to support women well during the antenatal period due to changes in the way care is being provided. Midwives reported that as a result of interim changes in the care model being implemented, their experience of being able to identify when a woman is struggling was changing. Some said they now had less time and a short visit was not enough to spot that women were struggling. They were concerned that problems would be missed.

3.12. Midwives also say the way call outs and on call arrangements are managed is getting in the way of great - and even safe - maternity care. Staff talk about “being pulled out” of their day job to work in the consultant led unit, and how disruptive that is. Working in different and unfamiliar environments is difficult and some staff feel it is risky.

3.13. **The findings suggest that whilst the current model is safe, further consideration needs to be given to how the performance and quality of midwifery led care can be further improved to achieve better outcomes for women and their families. Once published, the findings of the wider reviews currently taking place will also need to be taken account of.**

3.14. *Are there any concerns relating to rural access to the services?*

3.15. Antenatal and either community or inpatient post-natal care is delivered within women’s communities, but there is some geographical variability with regards to the local offer, and this is something that might be improved by consideration of alternative models of care. Any new model would need to reflect the need for all service users in Shropshire, Telford and

[4] The CCGs subsequently took action to look further into the concerns raised and take any action as required to ensure that services are safe and any issues regarding relationships between management and frontline staff are addressed.

Wrekin to have a consistent, accessible service, recognising the long travel times some rural populations face if they need to travel for Consultant –led care under the current system.

3.16. Families and staff told us that in Shropshire, Telford and Wrekin transport is a really important factor in their decisions and choices around birth and maternity care. People worried most about travelling to their place of birth when they were in labour and about birth before arrival. Because those who had to travel to the consultant led unit were usually also the ladies at highest risk, both staff and families worried that if more people were travelling and there was no or limited access to midwife services locally in case of emergencies, birth outcomes would get worse.

3.17. **The findings suggest that improvements to rural access could be made with regards to ensuring consistency in community provision across the county. Consideration also needs to be given with regards to whether the long journey times can be improved for the women needing to access consultant led care, but live a distance from Princess Royal Hospital.**

3.18. *Are the MLUs financially sustainable?*

3.19. SaTH have informed commissioners that MLUs cost £1million more to run than the income they receive from the maternity tariff for the midwife led units. Whilst the two larger MLUs operate below tariff, the three smaller MLUs in Bridgnorth, Ludlow and Oswestry operate at a loss (£355k, £666k, £699k respectively). However, the Midwife Led Units do not operate in isolation and activity and costs in other areas of the service/provider function impact upon the current financial position of the Midwife Led Units[5].

3.20. The biggest cost for MLUs is staffing. Therefore, it is important that this review considers how to ensure the staffing element is as efficient and effective as possible in order to get best value. It will be important to consider what skills are likely to be required during the day/night and in what volume. The current service configuration doesn't best meet demand. For example, at night each of the smaller MLUs has a midwife on site at the unit. This is the case whether there are women birthing/having a postnatal stay in the unit or not. However, at night the highest demand for midwives is in the consultant led unit, where currently they often have a shortage of midwives overnight.

3.21. A significant cost pressure relating to maternity services, including MLUs is in relation to the Clinical Negligence Scheme for Trusts (CNST). This is a scheme that NHS providers pay into in order for the NHS Litigation Authority to handle all clinical negligence claims that may arise. Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme. For SaTH maternity services as a whole, the cost of this is nearly £5.8million per year, with a proportion of this apportioned to MLUs.

3.22. Bridgnorth, Ludlow and Oswestry MLUs are sited in buildings not owned by SaTH. Therefore, there are additional costs associated with rent for these units.

[5] SaTH report losses of £7.263M against maternity services as a whole.

3.23. **The findings suggest that the driver for this review should be how to get services working as efficiently as possible, to get the best use of funds, staff and assets with the principle objectives being clinical sustainability, equity of access and improved outcomes.**

3.24. *Does the current model provide value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability?*

3.25. **Information gathered to date demonstrates the need to explore different service configurations that offer appropriate rural access, improved clinical outcomes, safety, and clinical sustainability alongside better value for money. Any new service configuration will need to ensure that systems are as efficient as possible and that staff expertise is utilised in the most effective way. In addition, better integration with other services would help to deliver an improvement in outcomes for women and their families.**

4. Proposed Changes

4.1. Not all of the proposed changes below relate directly to the midwife led care that SaTH provide. However, the wider changes for action by the Local Maternity System[6] have also been included here for completeness.

[6] The national review of maternity services 'Better Births' required each area in England to bring providers and commissioners together to operate as local maternity systems (LMS), to lead the transformation required in maternity services. Our local LMS is the Shropshire, Telford and Wrekin LMS. The MLU review is part of the transformation that will be delivered by the Shropshire, Telford and Wrekin LMS.

MLU Review Proposed Changes Summary Table		
Current Provision	**Proposed Provision**	**Rationale**
Pre-Pregnancy		
All women have access to universal public health services relating to healthy lifestyles. Women with a specialist need have access to mental health services provided by South Staffordshire and Shropshire NHS Foundation Trust (SSSFT).	It is proposed that, through the Local Maternity System, Public Health and Mental Health services are enhanced in order to provide multi-disciplinary information and support with regards to getting pregnant and being healthy during pregnancy. This should include information, advice and support from professionals in relation to: - Contraception and Sexual Health - Conception - Mental Health - Healthy Lifestyles - Long Term Conditions In addition, it is proposed that the services pre-pregnancy also offer comprehensive information on-line as well as facilitating peer support networks. New pathways, joint training and information sharing to enable professionals in different services to work well together, including improved information sharing, rotation of training across professionals and multi-agency information available on-line for professionals. Note : These services sit outside of the scope of the MLU review, but are included here for completeness. This proposal will be put forward to the LMS for action.	Health of women in pregnancy will be improved. This will facilitate a greater number of low risk, midwife led births as well as improving longer term health outcomes for women and their families.

Pregnancy		
Access to services is unclear and disjointed, with some women accessing services via their GP and some contacting maternity services directly. Women receive antenatal care from community midwives, who operate from 5 MLUs (1 x Alongside (AMU), 4 x Freestanding (FMU)) and 2 community bases. Ultrasound scanning is available in MLUs in most parts of the county. Day Assessment is available in MLUs in some parts of the county. Obstetric clinics are available in MLUs in some parts of the county. Women with an identified mental health need receive support through a specialist service provided by SSSFT.	It is proposed that access to maternity care is improved through self-referral via a single phone number to register directly with maternity services. In addition, improved electronic and online information should be developed, which includes a broad range of local information and advice for pregnant women and their families. Maternity Hubs across the county should be developed that are available for at least 12 hours a day for midwifery led care. A range of different services should also be available at the hubs. It is proposed that these maternity hubs replace the current model of MLUs for midwifery led care (note in the Birth section that it is proposed that 1 x AMU and minimum 1 X FMU are retained – these may also act as maternity hubs for those areas). The same services should be available in each of the maternity hubs at times which suit women accessing the services. The location of the hubs will be defined by likely population demand and will be easily accessible by car and public transport. Services available will include; - Antenatal care from a midwife - Support from Women's services assistants - Planned antenatal appointments with an obstetrician	The maternity hubs will ensure that women have equal access to services across the county. Women will have improved access to a range of services related to pregnancy – they can access them from the same place and can build relationships with peers accessing the services in order to support each other. The sustainability of the service will be improved through more integrated working and improved skill mix within the midwifery led care service. In addition, service availability will be shaped around local demand and activity. The staffing model will require fewer midwives to 'staff' bases, enabling more midwives to be able to flexibly respond to demand. Services will be close to home for women and more joined up. Local services will be available at times that suit the women who use them.

	- Scanning and fetal monitoring for all trimesters (not including labour) - Antenatal day assessment, including CTG monitoring - Support with emotional wellbeing and mental health (action for LMS) - Support with long term conditions during pregnancy - Healthy lifestyle services, including smoking cessation and weight management services (action for LMS) - Information and advice about pregnancy and parenthood including antenatal classes/groups, breastfeeding, baby care and life skills such as budgeting and cooking (some provided by SaTH, some for action by LMS) - Information and advice about birth options - Peer Support (action for LMS) A team of community midwives who have a caseload that is in line with national guidance will support women with planned antenatal care. They will have strong links with local GPs and will be supported by maternity support workers who are able to assist with tasks such as routine phlebotomy, urine testing and weight measurements. Women will have access to midwife advice and support 24/7. This will include advice	

	and support in person, through video call or over the phone. Women and the professionals working with them will have access to up to date information electronically (action for LMS). Peer support networks are in place, where women and their partners are able to link in with others if they want to, to share experiences through initiatives such as drop in 'cafes' and online networks (action for LMS).	
Birth		
Women have a full choice of birth options, delivered through: 1 x consultant led unit 1 x AMU 4 x FMU Home Birth	Women have a full choice of birth options and will be able to give birth at the consultant led unit at Princess Royal Hospital (PRH), at the Alongside MLU at PRH, a Freestanding MLU in Shrewsbury and at home. A community team will be available 24/7 for midwife led births in the midwife led units and at home. There will be improved pathways with maternity services over the border (particularly Wrexham, Hereford and Worcester) to facilitate easier access to services in those areas for women choosing to do so.	Clinical and Financial sustainability will be improved through more effective use of skill mix within teams. Whilst maintaining a full choice of birth options within county, reducing the number of MLUs will enable staffing to be deployed more effectively in line with demand. The current AMU, whilst technically an AMU as it is on the same site as the consultant unit, is not within close enough proximity to the consultant led unit for a greater level of risk to be safely managed in the AMU. Consideration needs to be given to re-locating the AMU closer to the consultant led unit in order to seek to facilitate an increase in midwife led births. SaTH are currently exploring this, as there are other services

		currently within the women and children's centre at PRH which could potentially be moved to elsewhere in the hospital, enabling the AMU to be closer to the consultant unit. The proposed model is designed to increase the number of midwife led births by: Over time, improving the health of women during pregnancy; Changing pathways in antenatal care so that all women receive care that plans for a midwife led birth, unless this won't be safe for the woman or her baby, or she chooses consultant led care for another reason; Enabling women to make a decision about their preferred place of birth later in pregnancy; moving the alongside midwifery led unit closer to the consultant led unit in order for a different level of risk to be safely managed.
Postnatal		
Women have access to inpatient postnatal care in MLUs and as outpatients at home.	A team of community midwives and women's support assistants will be available 24/7 to offer advice and support after the woman has given birth (this will be available from as soon as the mother returns home, or as soon as the midwife who delivered the baby at home has left). This support and advice will be available either in person, through a video call, or over the phone. Maternity Hubs across the county will be	Excellent postnatal care will be available consistently across the county. Clinical and Financial sustainability will be improved through more effective use of skill mix within teams and with staffing configuration better matching service demand.

	available for at least 12 hours a day for planned midwifery led care. A range of other different services will also be available at the hubs. The same services will be available in each of the maternity hubs at times which suit women accessing the services. Services available will include; - Postnatal care from a midwife - Support from Women's services assistants - Newborn checks and screening - Drop-in service or planned access during a 12 hour period to enable support, for example with feeding, confidence building, baby care skills - A space for women and their families to reflect on the birth experience - Support with emotional wellbeing and mental health - Support with confidence building and bonding - Support with feeding - Support with long term conditions postnatally - Healthy lifestyle services - Information and advice about parenthood including postnatal groups, infant feeding, baby care and life skills such as budgeting and cooking - Peer Support	

5. Options for service delivery

5.1. A number of options have been scoped out to evidence sustainability and cost effectiveness of the proposed service model. The options listed are not exhaustive. There are many other options available that would consider different skill mix, opening times etc. However, the following options provide a guide to potential staffing delivery models that demonstrate improved sustainability and efficiency.

5.2. The options below only include the staffing that will be required to staff the services which will have a particular building as a base. The proposed midwifery led care service model also includes 'community based' care, which will include unplanned antenatal and postnatal care delivered 24/7 at various locations in the community, including women's homes as well as some planned care delivered in the community. It also includes a 24/7 home birth provision. It is anticipated that the level of staffing associated with delivering this type of care may also see some efficiencies through increased skill-mix and better use of technology. However, this has not been explored in depth at this stage.

5.3. The attached options demonstrate that the proposed service model will be more sustainable than existing provision. In addition to improved use of technology, the improved sustainability will be achieved through:

- Reducing the number of sites requiring staffing 24/7
- Improving skill mix
- Releasing capacity to match demand

5.4. The attached options have been developed in line with guidance relating to caseload and midwife to birth ratios. All of the options include the retention of a full mix of birthing options through the provision of a consultant unit, an alongside MLU, a freestanding MLU and home birth provision all available 24/7 (unless stated otherwise). These will be supported by maternity 'hubs' across the county which will be open for 12 hours a day, offering antenatal and postnatal day care, maternal and neonatal assessment, ultrasound, and multi professional clinics and advice, volunteer and third sector support. These services will also be available at the alongside and freestanding MLU.

5.5. The options demonstrate that the proposed model could release up to 27 midwife shifts and 27 midwife support worker shifts per week, equating to over 17 WTE in total. The table below summarises each of the options (presented in more detail in Appendix 1) with additional commentary as to the suitability of each option.

Shropshire, Telford and Wrekin MLU Review : Options for delivery summary table				
Option	**Description**	**Efficiency**	**Viable?**	**Comments**
Current Provision: 1 x Consultant Unit 1 x Alongside MLU 4 x Standalone MLU		N/A	No	The service is currently not sustainable for the provider. The service configuration does not currently match demand and the availability of services is inconsistent across the county.
1	Change one rural MLU to a 12 hour Hub operating over either 5 or 7 days.	Will release: 5.76 WTE (5 days) 4.48 WTE (7 days)	No	Does not reflect the need for consistent services across the county. Does not reflect the need for staffing to be in line with demand. Does not release enough capacity to ensure sustainability.
2	Change two rural MLU to a 12 hour Hub operating over either 5 or 7 days.	Will release: 11.52 WTE (5 days) 8.96 WTE (7 days)	No	Does not reflect the need for consistent services across the county. Does not reflect the need for staffing to be in line with demand.
3	Change three rural MLU to a 12 hour Hub operating over either 5 or 7 days.	Will release: 17.28 WTE (5 days) 13.44 WTE (7 days)	Yes	Will enable consistent services across the county. Better matches staffing/services to demand.
4	Change three rural MLU to a 12 hour Hub operating over either 5 or 7 days and change the standalone MLU to operate for 12 hours a day over 7 days a week.	Will release: 21.76 WTE (5 days) 17.92 WTE (7 days)	No	Does not provide full choice of birth option 24/7.
5	Change three rural MLU to a 12 hour Hub and introduce an additional 12 hour Hub operating over either 5 or 7 days in the Market Drayton/Whitchurch area.	Will release: 14.08 WTE (5 days) 8.96 WTE (7 days)	Yes	Will enable consistent services across the county. Better matches staffing/services to demand. May not be as sustainable as Option 3.

5.6. Of the options explored, option 3 is felt to be the preferred model. Whilst Option 5 is optimal, it is not thought to be as sustainable as Option 3.

5.7. There are many variables possible within the options presented. The proposed service model is designed to be flexible, in order to adapt to changes in need and demand as required. In taking the recommendations of this review further, more detailed work will need to be undertaken with the service provider(s) to confirm the detail of the final model of delivery.

6. Summary and Conclusion

6.1. The service model proposed will improve clinical and financial sustainability and is in line with the requirements of Better Births. Access to care will be more consistent with a greater range of services available across the county. The service will aim to increase midwife led births through a number of initiatives, including moving the decision about preferred place of birth to later in pregnancy, linking in with public health schemes to improve the health of women in pregnancy and re-locating the alongside midwifery led unit closer to the consultant led unit.

6.2. The proposed model of midwifery led care is very different to the current service provision. Some elements of the proposed model may receive public challenge. However, the proposed new model will deliver an excellent, sustainable model of integrated care that is widely accessible across the county.

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Appendix 1

MLU Review : Proposed Model Staffing Options

Current configuration:

	Shifts	Midwives per shift	Total midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant Unit	2	12	24	2	4	7	168	28
Wrekin MLU	2	2	4	1	2	7	28	14
Shrewsbury MLU	2	1	2	1	2	7	14	14
Oswestry MLU	2	1	2	1	2	7	14	14
Ludlow MLU	2	1	2	1	2	7	14	14
Bridgnorth MLU	2	1	2	1	2	7	14	14
	12	**18**	**36**	**7**	**14**	**42**	**252**	**98**

Option 1a - One hub with 12 hour opening 7 days per week, reducing midwife shifts by 7 and MSW shifts by 7:

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant Unit	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
	11	**18**	**35**	**7**	**13**	**42**	**245**	**91**

Option 1b - One hub with 12 hour opening 5 days per week, reducing midwife shifts by 9 and MSW shifts by 9:

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant Unit	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
	11	**18**	**35**	**7**	**13**	**40**	**243**	**89**

Option 2a - Two hubs with 12 hour opening 7 days per week, reducing midwife shifts by 14 and MSW shifts by 14 :

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
	10	**18**	**34**	**7**	**12**	**42**	**238**	**84**

Option 2b - Two hubs with 12 hour opening 5 days per week, reducing midwife shifts by 18 and MSW shifts by 18 :

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
	10	**18**	**34**	**7**	**12**	**38**	**234**	**80**

Option 3a - Three hubs with 12 hour opening 7 days per week, reducing midwife shifts by 21 and MSW shifts by 21:

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
	9	**18**	**33**	**7**	**11**	**42**	**231**	**77**

Option 3b - Three hubs with 12 hour opening 5 days per week, reducing midwife shifts by 27 and MSW shifts by 27 :

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
	9	**18**	**33**	**7**	**11**	**36**	**225**	**71**

Option 4a - Three hubs with 2 hour opening 7 days per week, and the standalone MLU moves to 12 hours 7 days per week, reducing midwife shifts by 28 and MSW shifts by 28:

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
	8	**18**	**32**	**7**	**10**	**42**	**224**	**70**

Option 4b - Three hubs with 12 hour opening 5 days per week, and the standalone MLU moves to 12 hours 7 days per week, reducing middwife shifts by 34 and MSW shifts by 34:

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
	8	**18**	**32**	**7**	**10**	**36**	**218**	**64**

Option 5a - Four hubs with 12 hour opening 7 days per week, reducing midwife shifts by 14 and MSW shifts by 14 :

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	7	7	7
Additional Hub (Whitchurch/Market Drayton area)	1	1	1	1	1	7	7	7
	10	**19**	**34**	**8**	**12**	**49**	**238**	**84**

Option 5b - Four hubs with 12 hour opening 5 days per week, reducing midwife shifts by 22 and MSW shifts by 22:

	Shifts	Midwives per shift	Total Midwives per day	MSW per shift	Total MSW per day	Days Open	Total Midwife Shifts	Total MSW Shifts
Consultant	2	12	24	2	4	7	168	28
Alongside (Wrekin MLU)	2	2	4	1	2	7	28	14
Stand alone (Shrewsbury MLU)	2	1	2	1	2	7	14	14
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Oswestry/Ludlow/Bridgnorth Hub	1	1	1	1	1	5	5	5
Additional Hub (Whitchurch/Market Drayton area)	1	1	1	1	1	5	5	5
	10	**19**	**34**	**8**	**12**	**41**	**230**	**76**

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Shropshire, Telford and Wrekin Midwife Led Unit Service Review
Draft Review Report
6 December 2017

1. Introduction

1.1. Shropshire, Telford and Wrekin maternity services are provided by Shrewsbury and Telford Hospitals NHS Trust (SaTH). There are five Midwife Led Units (MLUs) that provide antenatal, birth and postnatal care in Shrewsbury, Ludlow, Oswestry, Bridgnorth and Wrekin, one of which (Wrekin) is on the same site as the Consultant Led Unit at Princess Royal Hospital in Telford. These units are supported by two Community Hubs at Market Drayton and Whitchurch where antenatal, home birth and postnatal care is provided.

1.2. The MLU operating model has remained consistent over the past thirty years undertaking all antenatal bookings and both high and low risk antenatal care for the Consultant Unit. The MLUs also deliver antenatal and postnatal community care, postnatal inpatient care as well as low risk births.

1.3. Shrewsbury and Telford Hospital NHS Trust have raised concerns regarding the sustainability of the current MLU model and in response, Shropshire Clinical Commissioning Group (CCG) has led a comprehensive service review on behalf of both Shropshire CCG and Telford and Wrekin CCG.

1.4. The purpose of Shropshire, Telford and Wrekin midwife-led unit service review is to review:

- whether or not the clinical model of delivery currently in place in Shropshire, Telford and Wrekin is clinically sustainable
- the safety of, and the clinical outcomes from, the current model and to establish whether or not these are acceptable for Shropshire, Telford and Wrekin patients
- any quality concerns relating to the service and make recommendations to address these
- staffing of the units to ensure this is appropriate for the requirements of the units and that there is a clear workforce plan to support service delivery
- any concerns relating to rural access to the services and make recommendations to address these
- the financial sustainability of the five MLUs. This can only be done within a financial review of the whole of the SATH Maternity service and tariff income
- whether the current model provides value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability and make recommendations to address this where this is not the case

1.5. Where the review identifies issues in relation to value for money, access, safety, quality, clinical outcomes, clinical sustainability or financial sustainability, alternative models of service provision will be developed in partnership with stakeholders.

1.6. This document reports on the findings of:

- Phase 1 (Analysis of existing information) of the Shropshire, Telford and Wrekin midwife-led unit review. Phase 1 has considered a range of existing information from a number of

different organisations. A summary of key documents considered for this review is available in Section 7 of this report.[1]

- Phase 2 (Gathering new information) which included gathering detailed information from women and their families as well as professionals working in or with maternity services.
- Phase 3 (Co-design workshops) which involved commissioners, women and their families, staff and community members with an interest in midwifery led care

1.7. The information gathered during Phase 1 and Phase 2 has been used to inform discussion in the co-design workshops in Phase 3. The proposed service model is based on the findings of Phase 1, 2 and 3.

1.8. In addition to addressing the specific requirements set for this review, the review has also considered any required service improvements in line with 'Better Births'[2] – a five year forward view for maternity care.

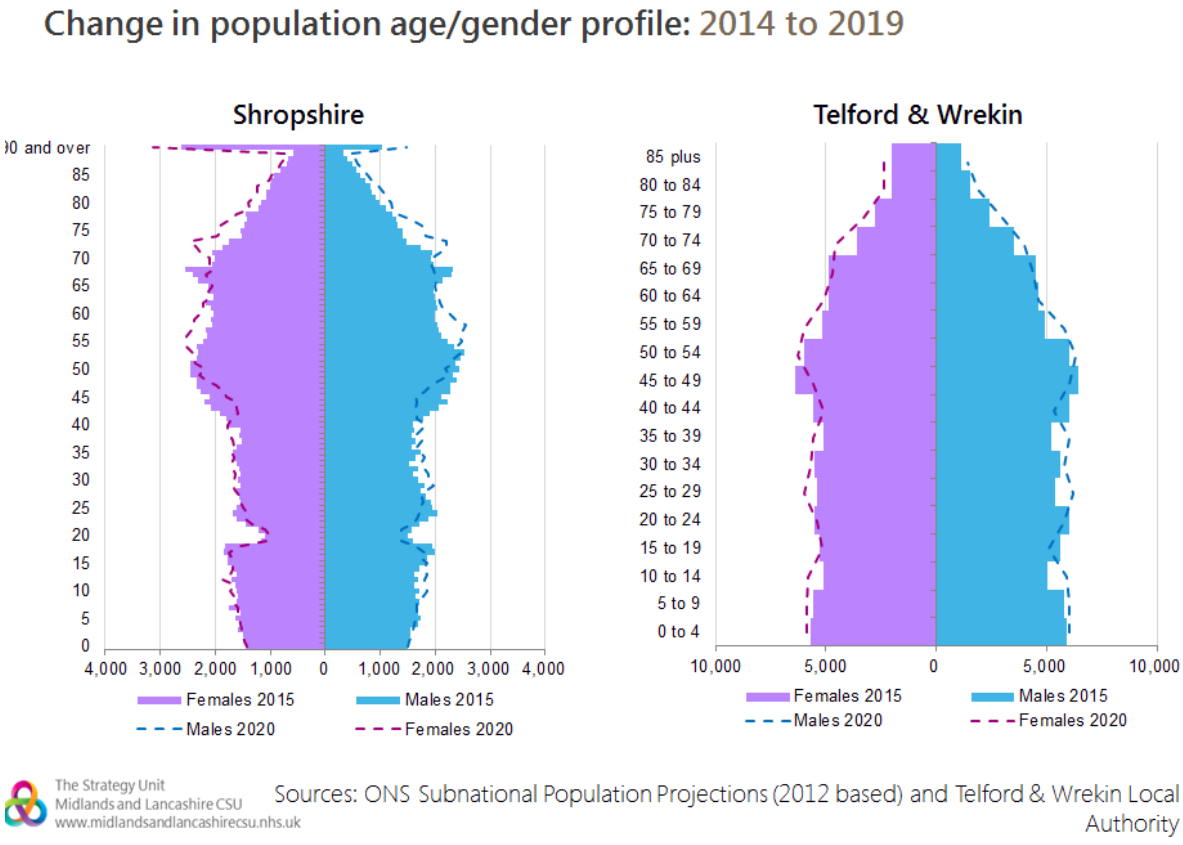
[1] Different organisations use a variety of data definitions and collection methods. As several data sources were used to inform this report, there is slight variability in some of the figures reported.

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Context

2.1. Local Context[3]

The overall population within Shropshire, Telford and Wrekin is approximately 480,000 people. Telford & Wrekin CCG has a large, younger urban population with some rural areas. Telford is ranked amongst the 30% most deprived populations in England. The population of approximately 170,000 is due to grow to 180,000 by 2020. Shropshire CCG covers a large rural population with problems of physical isolation and low population density. Shropshire has a mix of rural and urban areas and has an overall population of approximately 308,000 which is set to rise to 320,600 by 2020.



2.2. Just over a third of Telford and Wrekin's total female population (36%) are of child bearing age, which is similar to the national average (37%), this compares to 30% in Shropshire. Projections, based on national data, indicate that the numbers of women of childbearing age will remain relatively static in the next two decades. However, local data suggests that in Telford & Wrekin the female population aged 16-44 years will be almost 3,000 greater than the national expectations.

2.3. It is estimated that a significantly high level of adults (71%) in Telford and Wrekin carry excess weight (i.e. overweight or obese), which is significantly worse than the national average (64.8%). This equates to circa 22,250 women of child bearing age (15-44 years) in Telford and Wrekin, compared to 65.2% in Shropshire (30,900 women of child bearing age).

[3] Shropshire, Telford & Wrekin Sustainability and Transformation Plan

Overview of key routine maternal and infant population health measures January 2017 Public Health, Telford and Wrekin Council

2.4. Maternal smoking is significantly high in Telford and Wrekin, although in the past two years smoking at the time of delivery has started to decline. The rate of smoking in pregnancy in Telford and Wrekin was 18.1% in 2015/16, compared to 12.3% in Shropshire and 10.6% in England as a whole. A total of 367 women were still smoking at delivery in 2015/16, which compares to 297 women smoking at delivery in Shropshire.

2.5. Levels of breastfeeding (both initiation at birth and duration at 6-8 weeks) have been historically low in Telford and Wrekin. Although rates have been improving slowly, almost a third (32.5%) of infants (655 babies) were not breastfed at birth, which is significantly worse than the average for England 25.7%. In Shropshire just under a quarter, 24.7% of infants (605 babies) were not breastfed at birth in 2015/16, which is similar to the national average.

2.6. There are on average 14 deaths per year of infants under 12 months in Telford and Wrekin (2013-15). The infant mortality rate (6.5 per 1,000 live births) was significantly worse than the England average between 2011 and 2015. In Shropshire there are on average nine deaths under 12 months annually, the infant mortality rate (3.1 per 1,000 live births) is not significantly different to the England average.

2.7. The number of deaths during the first 4 weeks of life (neonatal deaths) in Telford & Wrekin has been increasing slowly in recent years by one case per year. The neonatal mortality rates in Telford & Wrekin from the period 2012-14 and 2013-15 were significantly worse than the England average. In Shropshire the number of neonatal deaths remains static and rates are similar to the England average.

2.8. <u>Overview of Key Maternal and Infant Health Measures</u>

	Telford & Wrekin		Shropshire		England
	No.	**% / rate**	**No.**	**% / rate**	**% / rate**
Demographic & socio-economic indicators					
Population: Total (2015)	171,200		311,400		
Population: 0-4 years (2015)	11,300	6.6%	15,100	4.8%	6.2%
Population: 16-44 females (2015)	31,300	36.3%	47,400	30.2%	37.1%
Children and young people (under 20) living in poverty (2013)	8,690	22.0%	6,970	12.0%	18.0%
Children (under 16) in low income families (2013)	7,760	23.0%	6,180	12.7%	18.6%
Women of childbearing age (15-44 years) living in deprived areas (2015)	8,900	28.6%	2,700	5.8%	21.9%
Fertility and conception rates					
General fertility rate (live births per 1,000 women aged 15-44 years) (2015)	2,075	64.1	2,795	56.9	62.5
Teenage pregnancy rates (under 18 conceptions per 1,000 females aged 15-17 years) (2014)	105	32.6	85	15.1	22.8
Maternal health and lifestyle					
Excess weight in adults (2013-15)	22,250	71.1%	30,900	65.2%	64.8%
Smoking at time of delivery		18.1%	297	12.3%	10.6%

(2015/16)	367				
Breastfeeding initiation (2014/15)	1,361	67.5%	1,844	75.3%	74.3%
Breastfeeding at 6-8 weeks (2014/15)	742	36.3%	1,272	45.9%	43.2%
Infant mortality and related indicators					
Births to mothers born outside UK (2013-15)	990	16%	813	10%	
Stillbirths in mothers born outside the UK (% of total stillbirths) (2013-15)		26%		14%	
Low birth weight of term babies (2014)	46	2.5%	69	2.6%	2.9%
Infant mortality rate (No. of deaths under one year per 1,000 births) (2013-15)	41	6.5	26	3.1	3.9
Stillbirth rate (No. of stillbirths per 1,000 total births) (2013-15)	12	4.3	9	4.2	4.4
Perinatal mortality rate No. of stillbirths and deaths under one week per 1,000 total births (2013-2015)		8.1		6.0	8.2
Neonatal mortality rate No. deaths of under 4 weeks per 1,000 live births (2013-2015)	10	4.6	6	2.2	2.7

2.9. National Context

NHS Hospital Episodes Data 2015-16 reports that there were 648,107 deliveries in NHS hospitals during 2015-16, an increase of 1.8 % from 2014-15. The number of deliveries for mothers aged under 20 has almost halved over the last ten years, from 43,572 deliveries in 2005-06 to 22,032 in 2015-16, whilst the number of deliveries for mothers aged 40 years and over has risen from 20,530 in 2005-06 to 24,942 in 2015-16, an increase of 21.5 %. The proportion of spontaneous deliveries has dropped from 64.8 % in 2005-06 to 60.0 % in 2015-16. Caesarean deliveries increased from 24.1 % to 27.1 % in the same period.

2.10. The national direction for maternity services was set out in the 2016 Maternity Review Report. *Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)* describes the way in which maternity services need to change. The seven key themes are outlined below.

2.11. *Personalised care.* This includes a personalised care plan for each woman, which sets out her decisions, reflects her wider health needs and is kept up to date throughout her pregnancy. It also includes women being able to access unbiased information through their own digital maternity tool, which enables them to access their own health records and information which is appropriate to them.

2.12. *Continuity of carer,* with each woman having a midwife who is part of a small team of 4-6 midwives. Each team of midwives should have an identified obstetrician. The woman's midwife should liaise closely with other professionals so that the woman's care is joined up.

2.13. *Safer care,* with professionals working together across boundaries to ensure rapid referral and access to the right care in the right place. Provider Boards should have a board level champion for maternity services and should promote a culture of learning and continuous improvement.

2.14. *Better postnatal and perinatal mental health care,* including significant investment in perinatal mental health services. Women should have access to their midwife and obstetrician, where appropriate, as they require after having their baby. There should be a smooth transition between services.

2.15. *Multi-professional working.* Those who work together should train together. Use of an electronic maternity record should be rolled out nationally, where the woman can share and can input the information that is important to her.

2.16. *Working across boundaries.* Community Hubs should be established where maternity services are provided alongside other services for families. Providers, Commissioners and other professionals should come together on a larger geographical area through Local Maternity Systems and Clinical Networks to work to common agreed standards and to share information, best practice and learning. Commissioners need to commission against clear outcome measures and take responsibility for improving outcomes and reducing health inequalities.

2.17. *A payment system* should be in place that is fair, incentivises efficiency and pays providers appropriately for the services they provide.

2.18. Saving Babies' Lives: A care bundle for reducing stillbirths (March 2016, NHSE) sets out the requirement to reduce stillbirths by 20% by 2020 and 50% by 2030. Saving Babies' Lives is a care bundle designed to support providers, commissioners and healthcare professionals to take action to reduce stillbirths and early neonatal death and brings together four elements of care that are recognised as evidence-based and/or best practice, these are:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

2.19. The key themes emerging from other national publications considered for this review are:

- The importance of choice and continuity of care
- The need for improvements in digital technology to support delivery of maternity services
- Outcomes-focussed commissioning
- The importance of supporting and developing the workforce
- Recognition that the risks and clinical needs of women are on the increase due to mothers giving birth later in life and an increase in other risk factors such as obesity
- The need for effective joint working between professionals, including seamless transfer between services

3. What we already know about the current maternity service in relation to Midwife Led Units

3.1. Overview

The table below provides a summary of the existing facilities within maternity services provided by Shrewsbury and Telford Hospitals NHS Trust.

Shropshire, Telford and Wrekin Maternity Services : Current Provision

Unit	Beds	Labour Rooms	Site	Comments
Consultant Unit Antenatal Ward	13	0	Princess Royal Hospital (Telford)	Also has: - 4 triage beds - a bereavement suite (labour room and living/meeting room) - side room (for triage/consultations)
Consultant Unit Delivery Suite	0	13	Princess Royal Hospital (Telford)	Includes 1 bereavement room. 1 labour room has a pool. Also has 2 theatres plus recovery.
Consultant Unit Postnatal Ward	23	0	Princess Royal Hospital (Telford)	Transitional care incorporated within.
Wrekin MLU	13	4	Princess Royal Hospital (Telford)	Antenatal, birth (MLU or homebirth) and postnatal care provided. One labour room has a pool. Additional consultation/clinical room.
Shrewsbury MLU	10	3	Royal Shrewsbury Hospital (Shrewsbury)	Antenatal, birth (MLU or homebirth) and postnatal care provided. Includes day assessment unit. One labour room has a pool.
Oswestry MLU	6	2	Robert Jones and Agnes Hunt Orthopaedic Hospital (Gobowen, Oswestry)	Antenatal, birth (MLU or homebirth) and postnatal care provided. One labour room has a pool. Additional clinic room for consultation and scans.
Ludlow MLU	4	1	Ludlow Community Hospital (Ludlow)	Antenatal, birth (MLU or homebirth) and postnatal care provided. A birthing pool is available in a separate pool room.
Bridgnorth MLU	4	2	Bridgnorth Community Hospital (Bridgnorth)	Antenatal, birth (MLU or homebirth) and postnatal care provided. One labour room has a pool.
Whitchurch Community Base	0	0	Whitchurch	Antenatal, homebirth and postnatal care provided.
Market Drayton Community Base	0	0	Market Drayton	Antenatal, homebirth and postnatal care provided.

3.2. The needs of women accessing maternity services are assessed and classified against 3 different pathways, which are defined at a national level (standard, intermediate and intense). Women with low needs are included within the standard pathways and those with the highest level of need are included within the intense pathways. The proportion of women within each of the different pathways in 2016/17 in Shropshire, Telford and Wrekin is provided in the table below and includes a comparison to other areas.

		Number (%) Women		
Stage of Pregnancy	**Level of Need**	**Shropshire**	**Telford & Wrekin**	**West Midlands CCGs 2015/16[4]**
Antenatal	Standard	1450 (51%)	892 (39%)	49.2%
	Intermediate	1134 (40%)	1147 (51%)	41.8%
	Intense	264 (9%)	220 (10%)	9%
Delivery	Without complications/co-morbidities	2133 (80%)	1720 (78%)	-
	With complications/co-morbidities	528 (20%)	473 (22%)	-
Postnatal	Standard	1643 (63.4%)	1097 (55.8%)	70.6%
	Intermediate	940 (36.3%)	860 (43.7%)	28%
	Intense	7 (0.3%)	9 (0.5%)	1.4%

3.3. Performance against quality indicators for maternity in 2016/17 was within the expected range and in line with national performance. However, there are a number of indicators for which performance is worse than the expected range. Indicators that were not within the expected range are given in the table below:

Descriptor	**Lower Limit**	**Expected Figure:** N = National Target, S = Birth Rate Plus Target, A = LSA Target, L = Locally agreed expected figure, B = Nationally Benchmarked	**Upper Limit**	**2016/17**	**2015/16**
% of births in Consultant Unit	70%	75-85% (L)	90%	**85.1%**	**82.3%**
% of births in any MLU	10%	15-25% (L)	30%	**14.4%**	**17.4%**

[4] Sandwell and West Birmingham CCG, Birmingham Cross City CCG, Birmingham South and Central CCG, Walsall CCG, Dudley CCG, Stoke on Trent CCG, Wolverhampton CCG, Shropshire CCG, Telford and Wrekin CCG, Solihull CCG, South East Staffordshire and Seisdon Peninsula CCG, North Staffordshire CCG, East Staffordshire CCG, Cannock Chase CCG, Stafford and Surrounds CCG.

% of births in a MLU or at home	10%	15-25% (L)	30%	**13.1%**	**16.1%**
Overall Assisted Births rate %		<10% (L)	25%	**10.2%**	**9.8%**
Caesarean Section rate %		<20% (L)	25%	**20.5%**	**19.4%**
Induction Rate %	15%	25-30% (L)	40%	**31.7%**	**30.7%**
% of bookings with a gestation of less than 12 weeks 6 days	85%	>90% (N)		**88.7%**	**91.7%**
% patients delivered who received 1:1 care during established labour	95%	100%		**97.5%**	**97.7%**

3.4. Analysis of performance to date in 2017/18 shows performance against the vast majority of quality indicators to be within the expected range.

3.5. Several reviews are ongoing at the time of writing this report in relation to the level of potential avoidable deaths within SaTH maternity services. The content of these review reports, once available will be considered in relation to the review of midwife led units in order to ensure the recommendations from this review are in line with any recommendations from other reviews currently taking place.

3.6. In general, midwife led units enable care to be provided close to home with many women living within 20 minutes (by car) of a midwife led unit. For some, access to the consultant led unit at Princess Royal Hospital is a longer journey with those in the far South West of the county experiencing journey times of up to an hour or more.

3.7. <u>Care before the baby is born (Antenatal Care)</u>
Women can book to receive maternity services through their GP or by booking with maternity services directly. Around 5,500 women book to receive maternity services at SATH each year.

3.8. The majority of antenatal care is delivered by community midwives. Rural community teams regularly have between 300-400 attendances a month. Wrekin and Shrewsbury community teams have around 2,500 and 1,200 attendances a month respectively. The clinics in Whitchurch and Market Drayton each have around 200 attendances a month.

3.9. Women can access antenatal care at a midwife led unit, one of the two community bases, a clinic at their GP practice or through the midwife visiting them at home. For those women who are considered high risk, they can access obstetric care through clinics at Princess Royal Hospital, Royal Shrewsbury Hospital or the hospital at which they plan to have their baby. There are also obstetric clinics held in Ludlow and Oswestry MLUs. All women have access to midwife advice over the telephone 24 hours a day, 7 days a week.

3.10. All women are routinely offered between 9 and 15 antenatal appointments throughout their pregnancy, dependent on their level of risk and term of pregnancy. At least one of these appointments will be in the woman's home. Women may have more appointments than this.

3.11. Women don't always see the same midwife throughout all of their care. However, community midwives mostly work in small teams with many GP practices having an allocated midwife, so women are likely to know the midwife they see during their pregnancy. Women are less likely to know the midwife caring for them when they give birth to their baby.

3.12. For antenatal maternal and fetal monitoring, women can access services at each of the MLUs as well as at the consultant unit. Pregnancy scans are offered at Royal Shrewsbury Hospital, Princess Royal Hospital, Oswestry MLU, Bridgnorth MLU or the hospital at which the woman plans to have her baby.

3.13. Giving Birth (Intrapartum Care)[5]

Women have a range of options in relation to where they give birth in Shropshire, Telford and Wrekin. These are:

- Consultant Unit (CU)
- Along-side MLU (on same site as consultant unit)
- Freestanding MLU (not on the same site as consultant unit)
- Home birth

3.14. SATH maternity services have around 5,000 births each year. Over 92% births are in relation to Shropshire, Telford and Wrekin patients. The remaining births are made up of Powys patients (4.4%) and patients from other areas (3.2% - mostly Staffordshire and Wolverhampton). The activity for 2016/17 is summarised in the table below. In 2016/17, 16 women from Telford & Wrekin and 152 women from Shropshire gave birth in other hospitals in England. Some women from Shropshire access services in Wales at Wrexham Maelor Hospital. In 2016/17 137 Shropshire Women accessed inpatient maternity services at Wrexham Maelor Hospital, this includes 106 deliveries. In England, the most common areas outside of Shropshire, Telford and Wrekin in which Shropshire, Telford and Wrekin women give birth are Birmingham, Wolverhampton, Chester, Cheshire, Staffordshire, Worcestershire and Wye Valley. Shropshire women give birth in a much greater range of hospitals than Telford and Wrekin women.

3.15. The number of babies born in Shropshire, Telford and Wrekin is summarised in the table below.

SATH Maternity Services : Births 2016/17				
Maternity Unit	**Shropshire Patients**	**Telford & Wrekin Patients**	**Powys Patients**	**Patients from other areas**
Consultant Unit	2,016	1,830	216	132
Shrewsbury MLU	142	0	0	0
Wrekin MLU	135	199	0	3
Bridgnorth MLU	67	2	0	8
Oswestry MLU	50	0	0	2
Ludlow MLU	31	0	0	5

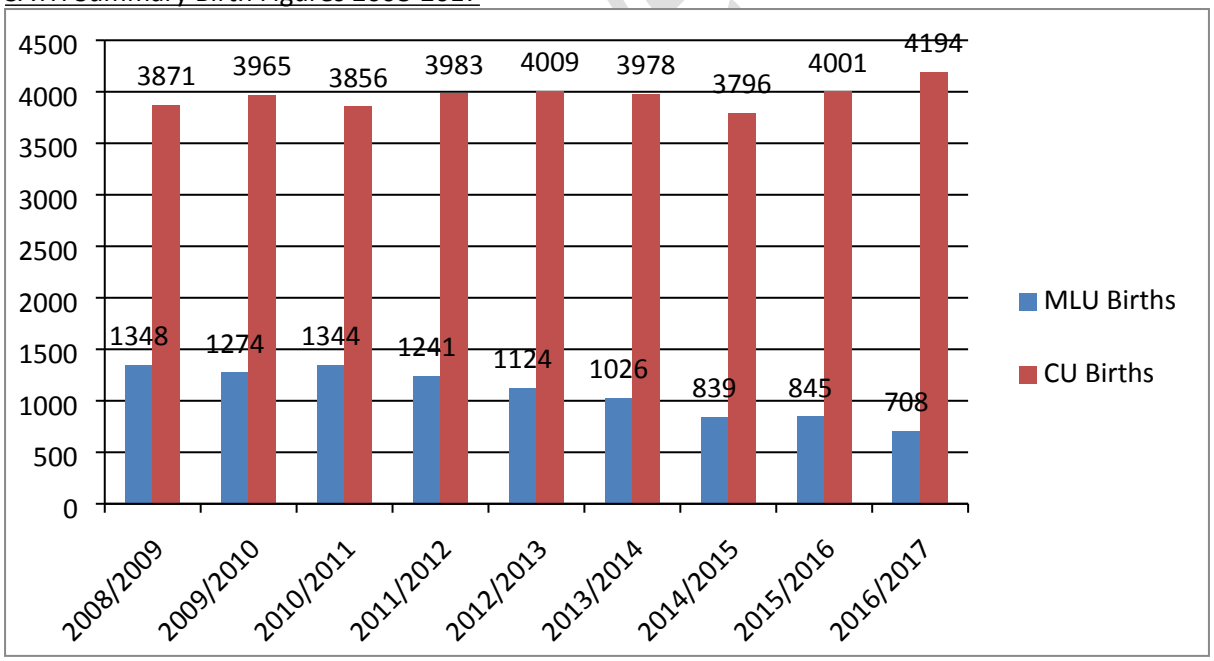
[5] Where numbers are given for 'births', this is the number of babies born. Where numbers are given for 'deliveries' this is the number of women who have given birth e.g. if a woman has twins, this will be one delivery but two births.

Home	41	21	1	1
Born before arrival (without presence of midwife or obstetrician)/other	8	8	2	8
Total	**2,490**	**2,061**	**219**	**158**
Total Births 2016/17	**4,928**			

3.16. For women registered with a GP in the north of Shropshire, in 2016/17 73.9% had their baby in Princess Royal Hospital, 12.2% had their baby in Wrexham Maelor and 5.8% had their baby in Oswestry MLU. A higher percentage of women registered with a GP in Shrewsbury and surrounding areas gave birth at Princess Royal Hospital (87.9%) with the remainder giving birth at Shrewsbury MLU (11.6%). 5 women from Shrewsbury and the surrounding areas gave birth further afield. Most of the women registered with a South Shropshire GP practice gave birth at Princess Royal Hospital (71.6%). 9.3% gave birth in Bridgnorth MLU, 4.5% had their babies at Ludlow MLU. The remainder gave birth out of county with most going to Worcestershire Royal Hospital (5.7%) and Hereford County Hospital (4.6%). Other places of birth for people registered with a GP in the south include Shrewsbury, Wrexham, Stoke, Wolverhampton and Birmingham.

3.17. Over the last nine years, the births within the midwife-led units or at home on the whole have declined from approximately 1350 (26% of total activity) to 708 (14% of total activity), as illustrated in the graph below.

SATH Summary Birth Figures 2008-2017



3.18. Of the women accessing SATH maternity services, 85.1% give birth in the Consultant Unit. This is in line with the findings of the national maternity review[6] (87% women nationally give birth in a consultant led unit). 13.1% give birth in a MLU with 3.3% of these women giving birth in one of the smaller MLUs in either Oswestry, Bridgnorth or Ludlow. 1.3% of women have home births. The remainder of births (0.5%) are born before arrival (BBA). This means the baby was born without a midwife or obstetrician being there.

[6] Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)

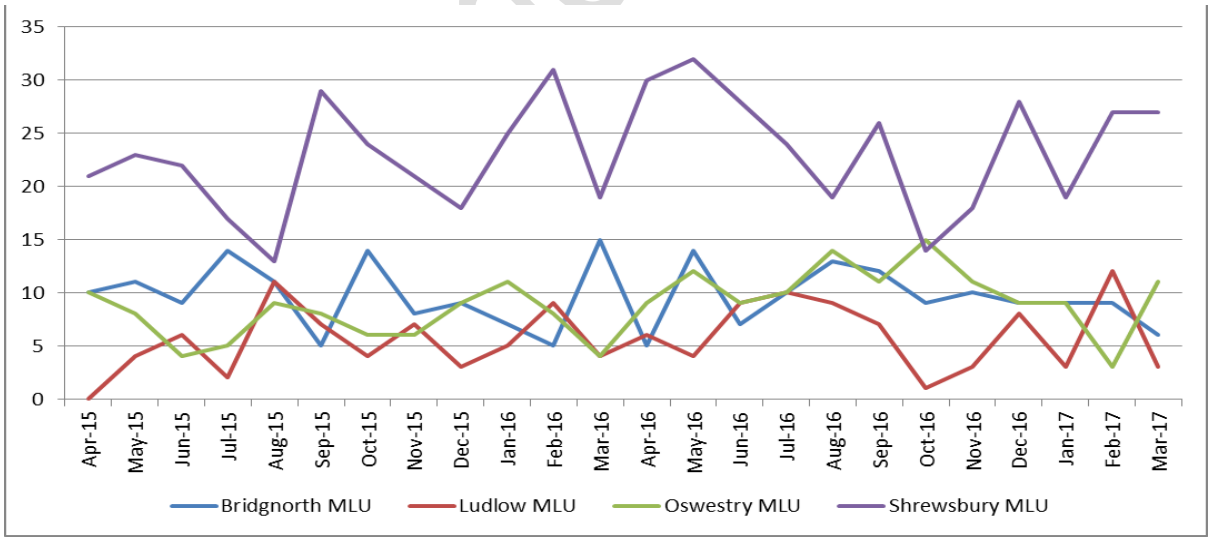
3.19. In Shropshire, Telford & Wrekin, many women intend to give birth at midwife led units, but go on to deliver in the consultant unit. In 2015 and 2016, 3,921 women intended to give birth in a MLU or at home. However, only 1,498 (38.2%) of women who intended to give birth in a MLU or at home actually did so. This compares to deliveries in the consultant unit in 2015 and 2016 where 95% of women who intended to give birth in the consultant unit (4,994), did so. The change of intended place of delivery most commonly occurs during the antenatal period and is usually associated with a change in risk to the mother or the baby.

3.20. A proportion of women start delivery at a MLU and are then transferred to a consultant unit. In 2015 and 2016, 723 women started their delivery at one of the MLUs but then transferred to the consultant unit for the birth of their baby.

3.21. <u>Care after the baby is born (Postnatal care)</u>

3.22. Most women (90%) and their babies who access inpatient postnatal care do so on either the Postnatal Care Ward at Princess Royal Hospital, the Wrekin MLU or Shrewsbury MLU. 10% of women receive some or all of their inpatient postnatal care at either Ludlow, Bridgnorth or Oswestry MLU.

3.23. In 2016/17 the MLUs cared for around 2,074 women postnatally who delivered their babies in the consultant led unit. The majority of these women were cared for postnatally at Wrekin MLU (1,406). Shrewsbury cared for 331 women postnatally, with Ludlow, Oswestry and Bridgnorth caring for 91, 106 and 140 women respectively. The Graph below shows the number of women who had a postnatal stay in one of the freestanding MLUs after giving birth in the consultant led unit from April 2015 – March 2017. The alongside MLU (Wrekin) cares postnatally for a much higher number of women who delivered their babies at the consultant led unit (around 80-118 per month).



3.24. On average women who have a postnatal stay, stay at the MLUs for around two and a half days. The number of women having a postnatal stay varies across the MLUs. In 2016/17 the MLUs each had between approximately 5 and 15 women each month having a postnatal stay. This doesn't include Wrekin MLU, which has a higher number of women staying each month.

3.25. The table below shows the total bed days available at the MLUs compared to the bed days used in 2016/17.[7]

MLU	Total bed days available per year	Total bed days used 2016/17 (% utilisation)
Wrekin	13 x 365 = 4,745	Not available[8]
Shrewsbury	10 x 365 = 3,650	647 (18%)
Bridgnorth	4 x 365 = 1,460	321 (22%)
Oswestry	6 x 365 = 2,190	570 (26%)
Ludlow	4 x 365 = 1,460	239 (16%)

3.26. Women and their babies are cared for by a midwife until the baby is 10 days old. Women are offered a minimum of two visits from a midwife at home after they've had their baby. The first will happen the day after they leave hospital/MLU. They will also have a visit 5 days after they go home. Some women may have more visits from a midwife.

3.27. After 10 days, the care is handed over to the health visiting service. The health visiting services in Shropshire, Telford and Wrekin are commissioned by Shropshire Council and Telford and Wrekin Council. Health visiting services across Shropshire, Telford and Wrekin are provided by Shropshire Community Health NHS Trust. The health visiting service will support the family until the child is 5 years old. Midwives use written information to handover care to the health visiting service. This is through recording information in the 'red book', which is left with women to share with the health visitor. In more complex cases, there may be more in-depth communication between the midwife and health visitor in handing over the care.

3.28. Workforce

3.29. SaTH employ a range of staff to deliver the maternity service. SaTH do not use any agency midwives to deliver the maternity service. The total staffing establishment is 270.09 whole time equivalent (WTE) and summarised in the table below (note: WSA = Women's Support Assistant):

[7] For example : One bed day = one woman staying overnight. Two bed days could be one woman staying for two nights, or two women each staying for one night. If all of the beds were used all of the time, the utilisation would be 100%.

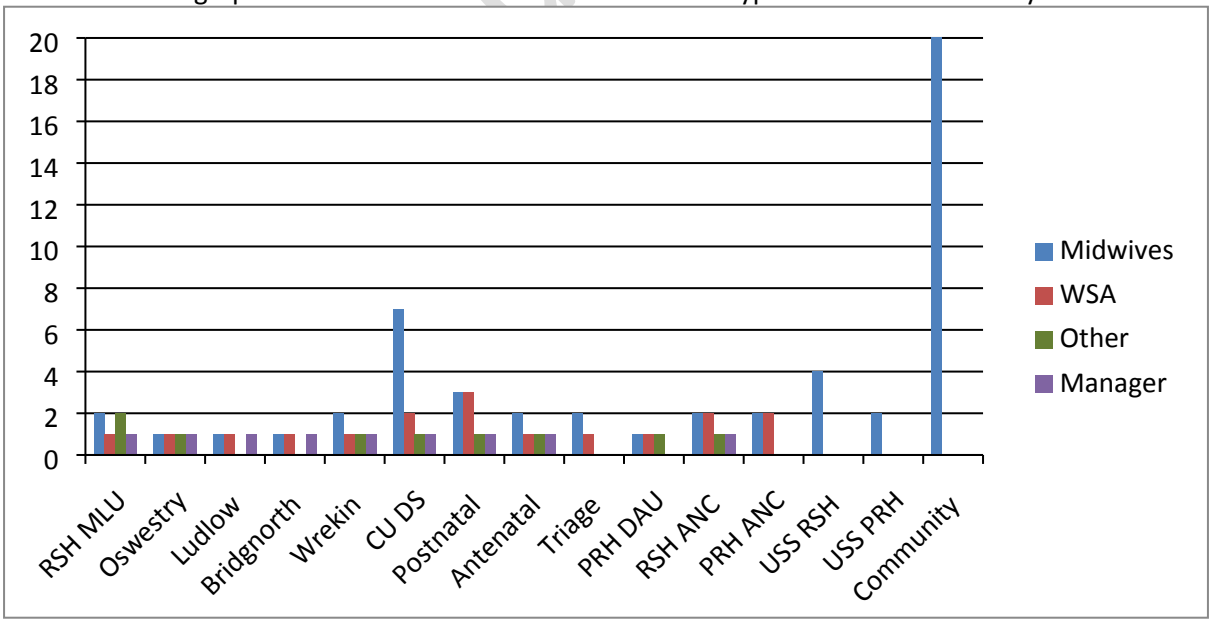
[8] Data is currently recorded by site. Information about postnatal stays specifically in the MLU was not available at the time of writing this report, as information relating to Princess Royal Hospital includes activity in the consultant unit as well as the MLU.

Staff	WTE
Midwives	153.78 WTE
WSA's	79.79 WTE
Assurance/Patient Experience	3.0 WTE
Information Team	2.2WTE
Specialist Midwives	7.6 WTE
Ultrasound Midwives	11.72WTE
Managers	12.0WTE (of which 3.2 WTE clinical)

3.30. As well as a lead midwife for the consultant unit and a lead midwife for community and MLUs, the service also has a number of specialist midwife roles, including:

- Bereavement
- Improving women's health (vulnerable women)
- Feeding
- Safeguarding
- Information Systems
- Guidelines
- Screening
- Education
- Public Health

3.31. Units are staffed with a mix of midwives, women's support assistants (WSA), managers and ward clerks. The graph below shows the number and type of staff on duty at a time.



Key : RSH MLU = Shrewsbury Midwife Led Unit
CU DS = Consultant Unit Delivery Suite
Postnatal = Consultant Unit Postnatal Ward
Antenatal = Consultant Unit Antenatal Ward
PRH DAU = Princess Royal Hospital Day Assessment Unit

RSH ANC = Royal Shrewsbury Hospital Antenatal Clinic
PRH ANC = Princess Royal Hospital Antenatal Clinic
USS RSH = Scanning at Royal Shrewsbury Hospital
USS PRH = Scanning at Princess Royal Hospital
Community = Midwives seeing women in the community

3.32. Midwives staff each of the units through shift and on-call arrangements. The current arrangements are detailed in the table below.

Midwife staffing arrangements			
Unit		**Shift**	**On call**
Consultant Led Unit	Delivery Suite	7	0
	Antenatal Ward	2	0
	Postnatal Ward	3	0
MLU	Wrekin	2	1
	Shrewsbury	1	1
	Bridgnorth	1	1
	Oswestry	1	1
	Ludlow	1	1
Total		**18**	**5**

3.33. A Birthrate Plus report was produced for SaTH in April 2017. Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making. The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birthrate Plus.

3.34. The BR+ report produced for SaTH maternity services suggests that an overall increase in staffing is required, but that the smaller MLUs are over-staffed for the level of activity. The BR+ recommended increase in staffing is detailed in the table below:

	BR+ recommended WTE	**Current WTE**	**Variance**
Consultant Unit	101.21	85.65	-15.56
Wrekin MLU	44.70	31.15	-13.55
Shrewsbury MLU	25.96	20.30	-5.66
Ludlow MLU	4.17	7.89	3.72
Oswestry MLU	6.93	8.20	1.27
Bridgnorth MLU	5.96	8.45	2.49
Whitchurch and Market Drayton bases	6.26	4.94	-1.32
TOTAL	**195.2**	**166.58**[9]	**-28.61**

3.35. BR+ states that for the MLUs and community bases, the shortfall of 13.06wte are not just midwives and a significant number can be appropriately qualified maternity support workers (MSW) assisting with postnatal care in the MLUs and community. Maternity support workers are the same type of

[9] Not including, Women's Support Assistants, Ultrasound Midwives or Managers

role as Women's Support Assistants. An estimated 10.66wte could be MSWs across the total community, reducing the midwifery shortfall to 2.40wte. For the consultant-led unit, an estimated 6.0wte could be appropriately qualified maternity support workers, reducing the midwifery shortfall in the consultant led unit to 9.56wte.

3.36. Historically, sickness and absence rates relating to maternity staff have been low. However, in recent months absence rates have increased which have put further pressure on services. This has led to the provider taking action to implement interim arrangements to ensure maternity services continue to be safe. The interim arrangements involve reducing the service at midwife led units, so that inpatient births and inpatient postnatal stays are not available at three of the smaller midwife led units.

3.37. Information and Record Keeping

Women have handwritten hand held notes, which they take with them to all appointments relating to their care during pregnancy. SaTH also hold handwritten hospital notes, to document any care provided in a hospital setting. The main information system used for electronically recording maternity care is 'Medway'. However, due to connectivity issues in the rural MLUs and community bases, it is not consistently available in all community settings currently used for maternity care.

3.38. SATH had previously sought to implement electronic record keeping in the community through digital pens. However, the project was not able to proceed as the provider was not confident in the accuracy/reliability of information being transferred onto Medway. It was not considered clinically safe to implement.

3.39. Further rollout of the Medway system is taking place in October/November 2017 and this will include more elements of activity also being recorded on Medway. SATH aspire to having all community antenatal and postnatal activity being recorded on Medway. However, this is not possible at this stage due to connectivity issues across the county.

3.40. Newborn physical examinations are currently recorded on Medway but due to a national requirement the NIPE examination will be recorded on NIPE SMART by Q3 2017. There are concerns that this fragmentation of information (i.e. that it is not recorded on Medway) may have associated risks. These are being considered by SaTH.

3.41. Finance

Maternity services are funded by a tariff (maternity pathway payment), which is set nationally. SaTH receive payment according to the number of women they have cared for at each stage of their pregnancy. The amount received will also depend on how high each woman's need is. The maternity pathway payment system splits maternity care into three stages: antenatal, delivery and postnatal. For each stage, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each stage to cover the cost of care, the level of which depends on clinical factors that affect the extent and intensity of care a woman is expected to need.

3.42. The amounts paid to the provider for each woman are summarised in the table below.

Maternity Pathway Payment		
Stage of Pregnancy	Level of Need	£ per woman
Antenatal	Standard	1,108
	Intermediate	1,629
	Intense	2,711
Delivery	Without complications/co-	1,819

	morbidities	
	With complications/co-morbidities	3,120
Postnatal	Standard	248
	Intermediate	313
	Intense	842

3.43. SaTH identifies a cost pressure of around £1m which relates to Midwifery Led Units. However, as MLUs are operating as part of a much wider service/set of services, there are lots of other factors that affect the income and cost.

3.44. The biggest cost for MLUs is staffing. Therefore, it is important that this review considers how to ensure the staffing element is as efficient and effective as possible in order to get best value. It will be important to consider what skills are likely to be required during the day/night and in what volume. The current service configuration doesn't best meet demand. For example, at night each of the smaller MLUs has a midwife on site at the unit. This is the case whether there are women staying in the unit or not. However, at night the highest demand for midwives is in the consultant led unit, where currently they often have a shortage of midwives overnight.

3.45. A significant cost pressure relating to maternity services, including MLUs is in relation to the Clinical Negligence Scheme for Trusts (CNST). This is a scheme that NHS providers pay into in order for the NHS Litigation Authority to handle all clinical negligence claims that may arise. Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme. For SaTH maternity services as a whole, the cost of this is nearly £5.8million per year.

3.46. Bridgnorth, Ludlow and Oswestry MLUs are sited in buildings not owned by SaTH. Therefore, there are additional costs associated with rent for these units.

3.47. The table below shows how many women from Shropshire, Telford & Wrekin (in 2016/17) received care within each of the different pathways. It also shows the total amount the Shropshire, Telford and Wrekin CCGs spent in 2016/17 relating to each of the pathways.

	Maternity Pathway Payment 2016/17				
Stage of Pregnancy	Level of Need	Number of women		Total Spend	
		Shropshire CCG	Telford & Wrekin CCG	Shropshire CCG	Telford & Wrekin CCG
Antenatal	Standard	1450	892	£1,573,250	£967,820
	Intermediate	1134	1147	£1,967,490	£1,990,045
	Intense	264	220	£762,696	£635,580
Delivery	Without complications/co-morbidities	2133	1720	£3,914,851	£3,151,756
	With complications/co-morbidities	528	473	£1,432,716	£1,282,870

Postnatal	Standard	1643	1097	£422,251	£281,929
	Intermediate	940	860	£303,620	£277,780
	Intense	7	9	£6,090	£7,830

4. What patients have said about the current Midwife Led Units

4.1. The majority of engagement for this review has been undertaken in Phase 2, using an 'Experience Led Commissioning' approach. This involves working in partnership with women who have used services to design the future model of service. It also gathered feedback from professionals and others with an interest in Shropshire, Telford and Wrekin midwife led units.

4.2. For Phase 1 of the review the following sources of existing patient feedback have been used:

- Shropshire maternity services usage – survey by MLU campaign group (2017) (Analysis of results by campaign group and analysis of results by Healthwatch Shropshire have been used)
- Feedback from patients received by SaTH
- Feedback from patients received by Healthwatch Shropshire October 2016-May 2017
- Feedback from patients received by Healthwatch Telford & Wrekin July 2016-June 2017
- CQC survey of women's experiences of maternity services at SaTH (2015)

4.3. The majority of feedback received from patients in relation to MLUs is positive.

4.4. In feedback to Healthwatch, women and their partners report positively in particular with regards to support provided postnatally with breastfeeding, confidence building and emotional support. Other positive feedback is in relation to the fact that services are close to home, women know the midwives and the environment in midwife led units is welcoming and relaxing. The negative comments received included those in relation to reduced access to services at midwife led units due to staff shortages and refurbishments.

4.5. The Shropshire maternity services usage survey identified that distance from home and continuity of carer are very important to women when choosing where to give birth. Women identified in-patient postnatal care as being very important to them in the Shropshire maternity services usage survey, with the top 3 reasons for women wanting a postnatal stay being; rest and recuperation, in order to establish breastfeeding and help and support to care for the new baby.

4.6. The results of the CQC survey about the whole of maternity services show that SaTH perform about the same or better than other trusts surveyed in relation to how positive patients reported about the service received, with most areas showing no statistically significant change in response compared to the same survey undertaken in 2013.

5. Key Findings and Considerations : Phase 1

5.1. The findings from Phase 1 have provided some evidence towards supporting a position in relation to each of the elements this review was set to consider. A summary of Phase 1 findings is provided below:

5.1.1. Is the clinical model of delivery currently in place in Shropshire, Telford and Wrekin clinically sustainable? Is the staffing of the units appropriate for the requirements and is there a clear workforce plan to support service delivery?

The findings of Birthrate Plus suggest that an increase in staffing is required in order for the current service to be sustainable. Recent increases in staff absences have increased the fragility of the service. The findings of the review so far suggest that the skills of existing staff aren't being utilised in the most efficient way. Women giving birth in consultant led units don't always get 1:1 care in labour, whereas women giving birth in midwife led units or at home have at least 1:1 care in labour (unless in exceptional circumstances, their baby is born without the presence of a midwife or obstetrician). There are other models of care which may offer greater sustainability and need to be considered.

5.1.2. Is the safety of, and are the clinical outcomes from, the current model acceptable for Shropshire, Telford and Wrekin patients? Are there any quality concerns relating to the service?

The CCG Clinical Quality and Review processes consider the safety and clinical outcomes from the current model to be acceptable. However, the outcomes and recommendations from wider reviews will need to be considered, once published. In addition, consideration needs to be given to how the current performance around safety and clinical outcomes can be further improved, as well as how midwifery services can work with other wider services, such as those commissioned by the Local Authority to further improve longer term outcomes for women and their families.

5.1.3. Are there any concerns relating to rural access to the services?

Antenatal and either community or inpatient post-natal care is delivered within women's communities, but there is some geographical variability with regards to the local offer, and this is something that might be improved by consideration of alternative models of care.
Any new model would need to reflect the need for all service users in Shropshire, Telford and Wrekin to have a consistent, accessible service, recognising the long travel times some rural populations face if they need to travel for Consultant –led care under the current system.

5.1.4. Are the MLUs financially sustainable?

SaTH report that MLUs cost £1million more to run than the income they receive from the maternity tariff for the midwife led units. Hence in their current form, the MLUs are not financially sustainable for SATH. Finance alone should not be a driver for this review however, rather, the review should look at how to get the services working as efficiently as possible, to get best use of funds, staff and assets with the main drive being clinical sustainability, right care, and best value.

The CCG is not in a position to pay any more than tariff for maternity services and therefore supports efforts to remodel services that will drive cost out for SATH whilst improving clinical sustainability.

5.1.5. Does the current model provide value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability?

Information gathered to date demonstrates the need to explore different service configurations that offer appropriate rural access, improved clinical outcomes, safety, and clinical sustainability alongside better value for money. This will involve ensuring that systems are as efficient as possible

and ensuring that staff expertise is utilised in the most effective way. In addition, better integration with other services would help to deliver an improvement in longer term outcomes for women and their families.

5.2. Phase 1 of the review has identified a number of other further considerations that need to be taken account of in developing a model for future services. These are detailed below.

5.3. Population numbers in Shropshire, Telford and Wrekin are increasing. Although national projections indicate the numbers of women of a child bearing age will be relatively static over the next two decades, local projections suggest the numbers may be higher. Rates of excess weight and smoking in pregnancy are higher in Shropshire, Telford and Wrekin than the national average. In Telford and Wrekin, rates are significantly higher. Neonatal mortality rates in Telford and Wrekin are significantly higher than the national average.

Consideration: How can the future model of service best meet these increasing needs of women and continue to offer choice?

5.4. Women in Shropshire, Telford and Wrekin have a choice of maternity provision, which is in line with Better Births. Women receive some maternity services close to home. Most women in Shropshire, Telford and Wrekin receive antenatal care from midwives they know, close to where they live, but deliver their baby in the Consultant Led Unit at Princess Royal Hospital where they often don't know the midwives. Some of these women want to give birth at a midwife led unit, but an increased clinical risk meant that they delivered their baby at the consultant led unit instead. The proportion of births at midwife led units is decreasing. The proportion of births at the consultant led unit is increasing, but is currently in line with national figures.

Consideration: Is there a way of enabling more women who want to have a midwife-led birth to do so?

Consideration: How can we increase the number of women who know the midwife who is delivering their baby and providing their postnatal care?

5.5. In general, quality indicators relating to the maternity service show that the quality of the service is at a level that the CCG require. However, a number of reviews are underway and the recommendations of these will need to be considered, once published.

Consideration: How can the future model of services help in delivering the recommendations of wider local reviews?

5.6. The maternity workforce is fragile. A recent Birthrate Plus report indicates that an overall increase in the number of maternity staff, including midwives is required, but that the smaller MLUs are over-staffed for the level of activity. Sickness and absence rates within maternity services have increased in recent months; So much so, that the combined factors of fewer staff and increased demand for the consultant unit has led to the provider taking action to re-distribute staff across the service. This has meant that a reduced service is currently being delivered within the smaller midwife led units, with the units being closed for inpatient births and postnatal stays. Community visits and home births are still available.

Consideration: How can the skill mix of staff be improved to ensure that the midwives are supported by others to enable midwives to focus their time on activity that they are especially trained to do?

Consideration: What can be done to ensure that staff with the right skills are in the right place at the right time?

5.7. Information systems and record keeping processes are time consuming and there is duplication. The provider is introducing more electronic ways of working, including electronic patient records, but these aren't yet in place.

Consideration: How can the future model of service include effective electronic information, both for women, their families and professionals working in or with maternity services?

5.8. The provider is reporting that the current model of provision is not financially sustainable.

Consideration: The review acknowledges the £1m cost pressure referenced by the trust for MLU services in their current form. How can the future model of services be as efficient as possible, work to get best use of funds, staff and assets?

5.9. Women and their families value the services provided by the midwife led units. They report positively about having services close to home with midwives that they know. Women feel that the units are welcoming and calming. Postnatal care provided by the midwife led units is regarded highly, particularly in relation to breastfeeding, emotional support and confidence building.

Consideration: What can be done to retain/build on the elements of service delivery that women and their families most value?

Phase 2 : Gathering new information

6. Gathering new information from women and their families and professionals about Midwife Led Units

6.1. Phase 2 of the review gathered in-depth information from women and their families who have accessed services as well as professionals working in or with maternity services. The information gathered was about their experiences of receiving or delivering maternity services. Phase 2 also offered an opportunity for others who have an interest in midwife led units to feed in their views.

6.2. An external organisation specialising in co-production (ELC Works[10]) was commissioned to lead Phase 2.

6.3. Information included in this report with regards to the findings from Phase 2 is taken from the detailed reports produced by ELC works.

6.4. Phase 2 included a series of in-depth interviews with women and their families and staff working in or with maternity services. A total of 132 parents with a child aged two or under participated in this phase of the programme. 108 lived in rural settings and 24 in urban settings. In addition, a further 37 families submitted evidence by email or in writing to the researchers. This was analysed separately and has been triangulated with formal research findings.

[10] http://elcworks.co.uk/

6.5. A total of 85 staff participated in the programme of in-depth interviews. The table below summarises their roles. 54 of the participants work in urban settings (MLU or consultant led unit) and 31 in rural settings (MLU or other community based). 40 participants work mainly in MLUs and 14 mainly in the consultant led unit. 27 work mainly in other settings.

Roles of staff participating in research	
Role	**Number of participants**
Early pregnancy assessment service (EPAS) staff	0
Midwives	56
Women's care assistants (health care assistants)	10
Health visitors	1
GPs	5
Obstetricians	4
Special care baby unit (SCBU) staff	1
Childrens hospice nurse	1
Breast feeding volunteer	1
Housekeeper	3
Clinical manager	2
TOTAL	**84**

6.6. The in-depth interviews found that family experiences across rural and urban areas are largely similar apart from birth and postnatal care where there are differences. The early days of pregnancy are characterized by a mix of emotions. Amongst those where nothing unexpected happens, emotions are often positive – even if the pregnancy is unplanned – although women may still feel anxious and overwhelmed. Where women require investigation or additional help and support early in pregnancy, some report feeling patronised. Families also report GPs being unhelpful. Relationships with clinicians – mainly midwives – are generally very positive. Some families report consultants being abrupt and 'scaremongering' them; although others report positive relationships with consultants. Generally experiences of planning and preparing for birth – including planned antenatal care are positive; with staff described as helpful, thorough and reassuring and appointments generally on time.

6.7. Those who work report antenatal care being a bit of a 'juggling act' and a few women mention getting mixed messages from staff. Generally, birth itself is regarded as a positive experience; although for some it is traumatic – especially when unexpected things happen. Those based in urban settings do not mention any challenges around reaching their place of birth nor anxiety linked to that. However, for this group, postnatal care (in the consultant led unit) is a far less positive experience, with wards described as busy and chaotic; the experience 'too clinical' and women feeling isolated and 'pushed out' of the ward as soon as possible. Women do not blame postnatal ward staff for this. They feel it is system/resource rather than a relationship problem.

6.8. Experiences of women in rural areas largely mirror those in urban areas with the exception of birth and postnatal care. Women in rural areas have the added anxiety and pain that comes from traveling a distance to hospital in labour. After birth, both groups report significant negative impact on their physical and emotional wellbeing. Those who feel unprepared for this – because they had less proactive antenatal care or missed out on classes – report that being unprepared can make it worse. The rural cohort had generally experienced postnatal care in an MLU and their experiences were extremely positive, with MLU postnatal care described as exceptional; peaceful; relaxing;

reassuring and a 'sanctuary'. Mum friends were important and a great source of support in both rural and urban communities. It is clear from this discovery work that having well developed networks of mum friends is protective and supports recovery from birth; smooths the transition to family life; builds parental resilience and helps new mums cope and keep well. Often antenatal and postnatal care facilitate connection and making mum friends – who often become friends for life. Becoming a family is generally a positive experience; although for some it is a shock and they feel nervous.

6.9. For staff, the journey is full of ups and downs currently. Whilst they enjoy good relationships with families and this is a highlight of their work, and they feel very supported by their immediate team and colleagues – a fact that is maintaining their personal resilience in the face of significant change and challenge within the provider Trust and the maternity service more broadly - relationships with colleagues beyond their immediate team are more fractured; and many people feel unsupported by management. This is more pronounced amongst staff based in MLUs and the community than those who work solely in the consultant led unit.

6.10. Staff report that antenatal and postnatal care are now very time pressured, and whilst in the past they delivered great family centred care, they feel this is changing as a result of changes made to the service. Birth is still a high point for most; although the unpredictable nature of birth; unrealistic expectations and a sense of being under-resourced get in the way. Whilst some staff have maintained a sense of control over their working lives, many feel they have no voice and no control at all. This is undoubtedly impacting on their emotional wellbeing and resilience. It is the underlying driver for staff reporting they wish to leave their jobs. It also helps explain high rates of absenteeism and sickness, which the picture this data paints suggests may be manifesting currently.

6.11. Based on participants feedback, the characteristics that participants feel make up good maternity care in Shropshire, Telford and Wrekin are presented as fifteen "design principles" below:

1. The system focus is towards "becoming a family", with great antenatal and postnatal care valued alongside safe births
2. Staff understanding of the impact of unexpected things on women early in pregnancy and of miscarriage should be an always event
3. Relationship centred system design including continuity of care and supporting midwives to work in small teams is a really valuable aspect of our current maternity service that this maternity system needs to preserve
4. Our maternity service needs GPs to feel interested and involved in supporting ladies who are pregnant
5. Consultants and families sharing decisions about birth and feeling able to have positive and sometimes challenging conversations about the risks and birth options is a good thing
6. A good personalised approach to care planning includes a flexible birth plan that covers antenatal, and postnatal care and recognises that unexpected things are very likely to happen to most families at some point in their journey so that families are open to discussions about different options when things change
7. Because of the rural nature of this community, having local routine care and local contingencies in place to deal with maternity emergencies safely across Shropshire, Telford and Wrekin is critical to great maternity service
8. Really responsive triage that provides quick, effective, personalised reassurance when unexpected things happen and that supports women to judge their progress in labour as accurately as possible so they get to their chosen birth place in time are vital design features of our maternity triage service – especially in rural localities

9. Having flexible antenatal appointments close to home, with time for discussion, good explanations and the chance to meet mums with a similar birth dates is key to a good antenatal experience
10. Good, safe birth experiences in Shropshire Telford and Wrekin need to be preserved
11. Good postnatal care really matters. Even though most of the benefits are realised in other parts of the NHS system, because it helps build the foundation for happy, healthy families from the start, investment in great postnatal care that delivers the following benefits is really important for community resilience:
    - Really good support with breast feeding
    - Having a safe space and support to reflect on and process the birth experience – especially when it has been traumatic for the mind and body e.g. an emergency caesarean or other difficult birth issues
    - Supporting bonding and connection with mum and the rest of the immediate family (partner and other children)
    - Transitioning to parenthood with confidence
    - Meeting and connecting with other women who often become life-long friends and a source of ongoing support

    Design needs to recognise that good postnatal care is even more important after a highly medicalised or traumatic birth – especially one that involves surgical intervention or physical injury.

12. The design of all routine antenatal and postnatal maternity care and environments, including wards, should support mums to interact, meet and make friends with others with children of the same or similar birth date.
13. How midwives and the maternity workforce feels really matters. The design of the maternity system needs to let midwives feel in control again, and involve staff in decisions, the planning and improvement of maternity care in Shropshire, Telford and Wrekin.
14. We very quickly need to design services and different ways of working that restore maternity staff resilience in Shropshire, Telford and Wrekin.
15. Maternity money flows, tariffs and outcome measures should all align better with what matters and support the creation of healthy, happy families alongside delivering babies so that other parts of the maternity journey are valued too. We need to measure different things within our maternity service in different ways, and in particular measure the things that staff and families have told us matter to them in these insights.

7. Key Findings and Considerations : Phase 2

7.1. The findings from Phase 2 have provided some evidence towards supporting a position in relation to each of the elements this review was set to consider. A summary of Phase 2 findings is provided below:

7.1.1. Is the clinical model of delivery currently in place in Shropshire, Telford and Wrekin clinically sustainable? Is the staffing of the units appropriate for the requirements and is there a clear workforce plan to support service delivery?

The findings from Phase 1, that the current workforce is fragile and staffing levels and skill mix need to improve in order to enable a stable workforce are supported by the findings from Phase 2.

Staff report that morale is low. Whilst in general relationships within teams are good, relationships with colleagues beyond their immediate team are more fractured; and many people feel unsupported

by management. This is more pronounced amongst staff based in MLUs and the community than those who work solely in the consultant led unit. Staff report that antenatal and postnatal care are now very time pressured, and whilst in the past they delivered great family centred care, they feel this is changing as a result of changes made to the service. Birth is still a high point for most; although the unpredictable nature of birth; unrealistic expectations and a sense of being under-resourced get in the way.

Families living in both rural and urban communities told us they experience continuity and that they value it highly. Families really value the support women's care assistants provide to them postnatally, particularly with breast feeding and caring for baby in the early days.

Women's support assistants and midwives report that recent changes are compromising the care they are able to offer as there is not enough time during appointments and home visits. Staff are worried that 'something will be missed' as they don't have enough time with women.

Increasingly, midwives do not feel in control of their working lives. They feel frustrated and angry. Staff feel disengaged from and let down by senior managers. Midwives report that not feeling in control is impacting on their work and home lives and on their emotional wellbeing, health and happiness. Staff feel they are letting their ladies down – especially in areas where there have been MLU closures.

Relationships between staff in the MLU and consultant led unit (CLU) were described as "them and us" by staff. This is exacerbated by the perception that the CLU "takes" MLU staff, but there is no reciprocity when MLU is busy. Families report mixed experiences of relationships with consultants and consultants recognised that building relationships with families could be difficult as generally they only got involved when things were not going to plan. MLU midwives in particular reported difficult relationships with the triage service. They described it as a battle to get women seen. Members of the triage team researchers spoke to did not mention these issues.

7.1.2. Is the safety of, and are the clinical outcomes from, the current model acceptable for Shropshire, Telford and Wrekin patients? Are there any quality concerns relating to the service?

Whilst women did not report any issues relating to quality and safety, some concerns were raised by midwives.[11]

Midwives reported that changes in working practices were compromising continuity and their close relationships with women. Midwives perceive that it is becoming more difficult to support women well during the antenatal period due to changes in the way care is being provided. Midwives reported that as a result of changes in the care model being implemented, their experience of being able to identify when a woman is struggling was changing. Some said they now had less time and a short visit was not enough to spot that women were struggling. They were concerned that problems would be missed.

Midwives also say the way call outs and on call arrangements are managed is getting in the way of great - and even safe - maternity care. Staff talk about "being pulled out" of their day job to work in the consultant led unit, and how disruptive that is. Working in different and unfamiliar environments is difficult and some staff feel it is risky.

[11] The CCGs subsequently took action to look further into the concerns raised and take any action as required to ensure that services are safe and any issues regarding relationships between management and frontline staff are addressed.

The findings from Phase 2 support the findings from Phase 1 that consideration needs to be given to how midwifery services can work with other wider services to further improve longer term outcomes for women and their families.

7.1.3. Are there any concerns relating to rural access to the services?

Families and staff told us that in Shropshire, Telford and Wrekin, transport is a really important factor in their decisions and choices around birth and maternity care. People worried most about travelling to their place of birth when they were in labour and about birth before arrival. Because those who had to travel to the consultant led unit were usually also the ladies at highest risk, both staff and families worried that if more people were travelling and there was no or limited access to midwife services locally in case of emergencies, birth outcomes would get worse.

7.1.4. Are the MLUs financially sustainable?

Information relating to the cost/financial sustainability of MLUs was not gathered through Phase 2.

7.1.5. Does the current model provide value for money in terms of cost, rural service access, clinical outcomes, safety and clinical sustainability?

Phase 2 did not consider information relating to cost. However, findings in relation to rural access, clinical outcomes, safety and clinical sustainability can be used to inform the overall position with regards an assessment of overall value for money.

Phase 3 : Co-design workshops

8. Co-design workshops

8.1. Phase 3 included a series of co-design workshops at which women and their families, professionals and others with an interest in midwife led units came together to discuss what the future model of midwife led services may look like.

8.2. This section of the report summarises the findings of Phase 3 and sets out the feedback from the community about the way forward for midwife led maternity services. The ideas described in this section were generated at 9 co-design workshops held across the county in September 2017. The table below summarises the locations and attendance for each co-design workshop.

Co design workshops	
Venue	**Attendance**
Shrewsbury (day time)	26
Oswestry Workshop	30
Ludlow Workshop	28
Bridgnorth workshop	22
Shrewsbury (evening)	6
Telford	12
Market Drayton	7
Additional session Shrewsbury (evening)	1

8.3. In total 127 people attended the workshops, as 5 people listed in the workshop attendance attended two workshops.

8.4. The shared ambition developed through the co-design workshops responded to and built on the findings from Phase 1 as well as the insights generated from Phase 2. The key elements of the shared ambition developed through the co-design workshops (Phase 3) are described below.

8.5. The importance of healing history[12]: Participants recognised that there has been a difficult shared history over the last few months, with significant loss of trust in the "system" and a perception amongst community leaders that decisions had already been made. This has been fuelled recently by messages about a new care model issued by Shrewsbury and Telford Hospitals Trust (SaTH), which has continued to muddy the water. These messages were not aligned with commissioners' intentions, expectations nor with the timeline for the commissioners' decision making process.

8.6. Shropshire, Telford and Wrekin commissioners have been absolutely clear in the public domain that no decisions have been made about the care model, and that the community will be involved in the decision-making process moving forward.

8.7. The community fed back at workshops that the Midwife Led Unit (MLU) Review could not be seen in isolation from other ongoing reviews e.g. Future Fit; The Ovington Review; The Secretary of State Review. Decisions within those reviews would impact on the community's perception and expectations of the MLU Review.

8.8. There was a recognition that the MLU Review needed to be linked to other reviews and activity taking place e.g. initiatives around neighbourhood working.

8.9. There was a need to regain trust and start being respectful towards each other. All stakeholders agreed that it was time to heal recent history and move forward positively and together for the sake of the future maternity service and so that this shared ambition can be fully realised.

8.10. Overarching Principles : The community identified 7 overarching principles for the service model that were especially important. They were:

- Safe births
- Equality and sustainability across the county
- Everyone being treated with respect and as an equal

[12] "Attending to history" is recognised by health service researchers as a critical success factor for larger scale transformation and change management https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3479379/

- Family and community centred care
- A more social and less medical model of care
- Partnership working
- Maternity staff being fully involved in care model development

8.11. Specific elements of the care model : There was great synergy across all workshops, which suggests that the elements described here are the main ones to focus on. They also closely align with the insights generated from Phase 2.

8.12. The community wants both families and maternity staff to have a positive experience and be safe throughout their respective journeys. They described key elements of the care model that the community values most, and that any future midwife led service design needs to incorporate. They said we want:

8.12.1. Midwife led care to support families to thrive

The community wants to start with the end (outcome) in mind and work backwards from there. The current maternity service focuses mainly on birth. The community wants the system focus to be family life. By broadening the system focus, antenatal and postnatal care and support transition to healthy family life becomes valued as well.

8.12.2. Midwife led care is relationship-centred and builds community

The community wants service design and delivery that supports strong relationships and connections between midwives and women and their families and between parent peers (strong mum friendships circles). This means a maternity service that supports continuity of care, with one midwife or small teams of local midwives working together to support women and families they know through their journey from antenatal to postnatal.

A relationship centred care model means having contact with all women within their communities, and creating time to talk and discuss what matters to parents – especially when unexpected things happen. It means routine antenatal and postnatal care being delivered differently and potentially in group clinic settings instead of mainly one to one.

8.12.3. Midwife led care responds to a 'family centred plan'

The community recognised that the term "birth plan" reinforced the system's narrow focus on birth. Because they wanted the service to take a broader focus and value antenatal and postnatal care too, the name of the plan needed to change to signal a fundamental change in emphasis. Home birth was a choice that should be available as well. The plan needed to encompass the whole journey towards becoming a family and recovering beyond birth – including a plan for postnatal care and one that supported transition into early years' services (health visiting and children's centres support).

Managing expectations, sharing decisions, knowing their choices and making informed ones was also an important element of the family plan. Whether women were high or low risk, feeling involved in decisions was very important to them. The whole family needed to be involved and recognised in the

family plan, including partners. Mapping and recognising the level of family support an expectant mum had was also critical to a personalised family centred plan – especially when a woman had no family to support her. Avoiding stereotyping mothers who have had previous pregnancies and have other children was also important. Every birth is unique and different.

The community felt also that currently expectant parents had to make their choice about place of birth too early, and this decision should be deferred to 36 weeks. This was proposed as a bold step. Staff also needed to be equipped and have tools to support and promote choice and to identify and support vulnerable families so they got the right support.

8.12.4. Midwife led care responds proactively and equally to physical and mental health issues

Maternal health is critical to families thriving. The community said that access to support when a parent was experiencing mental health issues needed to improve. They wanted parity for mental health issues, and for parents to have access to help when they needed it so they keep well in both mind and body.

8.12.5. Midwife led care is provided in the heart of the community

The community recognised that there are many existing services that support family life, and they could be joined up and centralised. The community talked about the potential for midwife led services to be delivered from community places that had a broader social rather than a medical purpose. These centres would build on the places and things communities already have, and be different in different communities, responding to the particular needs of that community e.g. in market towns in South Shropshire, transport access can be difficult which would affect location of the centre. In other areas, the centre might be in the middle of town or in children's centres, maternity clinics or village halls. In other areas, the centre might be located in a place that is easier to access through existing transport links.

In this way, family support services, including maternity services, would become highly personalised to communities and not just to families. These places would also be strongly community led – potentially social enterprises with local parents involved in setting them up and running them. There would be Wifi, refreshments and play areas so that families could drop in; build social networks and connections. They would help eliminate social isolation. Breastfeeding support, childcare and parenting groups could be based here.

These places would be opening and welcoming and designed to be accessible - not only from a transport point of view; also culturally e.g. parents under 25 as well as parents over 25; those with complex health or social circumstances or who have a disabled child, and those who work would all feel included, and supported to network with peers who share their experiences and understand their personal challenges. There needed to be out of hours support for working women and their partners.

These places would also be an environment that supports staff development. They would link and connect multidisciplinary teams of professionals, providing planned care and support to families from these centres. Consultants could consult in these centres. They would provide a focus for GPs to stay connected.

There are already places in many communities that could offer a home for this kind of midwife led care, and mapping those community resources would be an important next step. Working from the same place would build more empathy and positive relationships between professionals and also join up referrals and care planning.

These centres would in effect become the central focus within communities for those expecting a baby or raising a child. Amongst many other things, they would offer:

- *Information and advice*
- *Access to routine care and support and reviews before and after birth and into early years*
- *Signposting e.g. breastfeeding support; voluntary sector*
- *Mothers' groups and community building across antenatal and postnatal care.*
- *They could also harness positive community building through social media – facebook/ twitter and what'sapp to keep local mums connected in the virtual world.*

A recurrent theme across several of the workshops was the idea of remote communities having access to a 'mobile pregnancy and early years services' that mirrored this model and came to where women live.

There was support for this community-based model across all workshops. The role of MLUs within the context of that model was not discussed in detail. However, views in relation to the role of MLUs in the future model varied. Community workshop participants called both for MLUs to be open 24/7; be staffed with higher band staff and offer antenatal and inpatient postnatal care and to be closed because there are too few births in MLUs.

Several workshops also recognized and proposed that postnatal care could be home based, and antenatal care could also be provided in settings other than an MLU.

Some members of the community believed all women wanted MLU births – or that they would want them if there was more balanced media coverage about MLUs and women knew that MLU deliveries were safe and available. This was challenged by experienced maternity staff at workshops who reported that women – even women who fell into the low risk birth category – were voting with their feet and choosing birth in the consultant led unit. This made it challenging to increase birth rates at MLUs.

The community recognised that negative press coverage fuelled this shift, and more could be done to promote MLUs as a very safe place to give birth. The community felt that the local press, maternity staff, commissioners, SATH, and local campaigners all owned the challenge of changing perceptions about MLU birth.

A bold step to reverse the current trend that came from this same workshop was that women should not have a choice and if their risk was low, the default should be an MLU birth.

8.12.6. Support early in pregnancy

Caregivers need to acknowledge women's birth histories, which may include traumatic experiences and memories that impact across subsequent pregnancies. Acknowledging women's feelings and the need to heal is important – especially in early pregnancy. Some people felt that vulnerable women

may need support earlier in pregnancy, and one workshop felt that women needed better information early in pregnancy.

8.12.7. Great perinatal mental health support

Reflecting the principle that emotional and physical wellbeing are equally important, people wanted improved and more proactive support for women experiencing mental health issues during pregnancy and into early years and training in perinatal mental health for staff across maternity and early years.

8.12.8. Review risk classifications and management of high risk women

An issue that emerged at several workshops and in the insights generated by Phase 2 was that the current risk stratification process gets in the way of more women being eligible for MLU births. The community wanted to see a review of the current risk classification framework, and also strongly supported an idea floated at several workshops (a bold step) that assessment of a woman's risk should happen later in pregnancy - around 36 weeks - rather than channelling women into the 'high risk' category in the first trimester as currently occurs. The community believed that closer connectivity between providers like public health and GPs could also help make risk assessments more accurate – and even help reduce risk e.g. weight loss and smoking cessation services. The community also suggested that expert peers and midwives as well as specialists could and should support discussions about risk and choice.

8.12.9. A safe, familiar place to give birth

The community saw safe births as an extremely important element of the midwife led care model. It was in the top three most important elements of care and support, as voted for by participants in this co-design process. Because it is a rural county, giving birth in a safe place needed to take account of travelling times. One workshop suggested there needed to be a 'maximum travel time to get to place of birth' as a service quality criteria.

The community also asked that the consultant led unit be moved to a more central location within the county. Technology was recognised as an important enabler of connectivity and care; potentially supporting safe triage. One workshop also suggested birth centres offering virtual tours to support women's decision making process and choice. However, participants felt technology could not replace human contact.

8.12.10. Great postnatal care for everyone

The community wants excellent postnatal care for everyone, with urban and rural areas on a par. The community recognised that some women need inpatient postnatal care, and this should be great when it is delivered. Postnatal care involves both maternity teams and health visitors. The community recognised the impact of 60% cuts in health visitor budget and one workshop called for more health visitors. Current system design means that boundaries are rigid and staff feel pressure to discharge and transfer care at 10 days. Current boundaries may be artificial and service rather than family and relationship centred.

Several workshops recognised that postnatal care could be home based, and both post- and antenatal care could be provided in settings other than an MLU. Breastfeeding support was important. For new mums to gain confidence and succeed, it needed to be available over time and beyond initiation.

Two workshops proposed 'on call 24/7 advice with a real person at the end of the phone to offer support'. Consistency of advice was important. Two workshops suggested that education about breast feeding needed to start during antenatal care.

There was very strong message that health visitors and midwives should work much more closely together to deliver postnatal care and support.

8.12.11. Well supported, trained staff; new workforce models

The community wants their frontline maternity staff to have a bigger say and be more involved in the improvement of midwife led care. They want staff to be well trained and supported, and to work in environments that support personal and professional development. Their managers need access to leadership training.

They want maternity staff to have the right skill mix to support women safely and appropriately, and for midwives to have more flexibility, power and autonomy for delivering outcomes. Lone workers need to be supported well when doing call outs.

Training and information systems need to ensure one clear message to families. There needs to be a plan in place to address recruitment and retention in midwifery. One workshop called for expansion of employment opportunities and for nurses to train to expand the midwifery workforce. One workshop called for more staff. There was also a call for professional boundaries to be explored to bring in skills held by other people and organisations.

In terms of workforce development, the community suggested new roles with maternity care:

- *Trained peer supporters / buddies*
- *Consultant midwives*
- *GPs with a special interest in maternity care*
- *Lactation consultants*
- *Midwife support workers*
- *Extended roles for womens' support assistants (WSAs)*

The community also embraced opportunities for a broader range of providers. Some participants also wanted GPs to be more involved.

8.12.12. Improved communication and joint working

Improving communication and more effective working relationships across the service was a recurrent theme. The community believed that improving personal relationships; having up to date and integrated IT systems and integrating planning would lead to closer collaboration and more joined up working. Being co-located in the same community place could help too.

One workshop suggested there should be closer collaboration and greater connectivity with services that work to reduce risks in pregnancy to lower the risk profile of women more proactively e.g. weight management services; smoking cessation.

8.12.13. A model built on evidence and best practice

The community said that the midwife led care model needed to build on research evidence, local knowledge, best practice and NICE guidance about what works and delivers good outcomes. The community supports Better Births policy. Learning from the maternity vanguard pilots as well as other national archives of best practice needed to inform the way forward.

The community also wanted to learn from local best practice and it wanted to involve staff in service improvement and design.

8.12.14. New outcomes and measures of impact

There was strong support for measuring value in a different, more family outcomes focused way. There was also recognition that the same or very similar outcomes matter from -9 months to early years, and that shared outcomes could support joined up budgets, commissioning and integrated provider working.

Proposed service model

MLU Review Proposed Changes Summary Table		
Current Provision	**Proposed Provision**	**Rationale**
Pre-Pregnancy		
All women have access to universal public health services relating to healthy lifestyles. Women with a specialist need have access to mental health services provided by South Staffordshire and Shropshire NHS Foundation Trust (SSSFT).	It is proposed that, through the Local Maternity System, Public Health and Mental Health services are enhanced in order to provide multi-disciplinary information and support with regards to getting pregnant and being healthy during pregnancy. This should include information, advice and support from professionals in relation to: - Contraception and Sexual Health - Conception - Mental Health - Healthy Lifestyles - Long Term Conditions In addition, it is proposed that the services pre-pregnancy also offer comprehensive information on-line as well as facilitating peer support networks. New pathways, joint training and information sharing to enable professionals in different services to work well together, including improved information sharing, rotation of training across professionals and multi-agency information available on-line for professionals. Note : These services sit outside of the scope of the MLU review, but are included here for completeness. This proposal will be put forward to the LMS for action.	Health of women in pregnancy will be improved. This will facilitate a greater number of low risk, midwife led births as well as improving longer term health outcomes for women and their families.

Pregnancy		
Access to services is unclear and disjointed, with some women accessing services via their GP and some contacting maternity services directly. Women receive antenatal care from community midwives, who operate from 5 MLUs (1 x Alongside (AMU), 4 x Freestanding (FMU)) and 2 community bases. Ultrasound scanning is available in MLUs in most parts of the county. Day Assessment is available in MLUs in some parts of the county. Obstetric clinics are available in MLUs in some parts of the county. Women with an identified mental health need receive support through a specialist service provided by SSSFT.	It is proposed that access to maternity care is improved through self-referral via a single phone number to register directly with maternity services. In addition, improved electronic and online information should be developed, which includes a broad range of local information and advice for pregnant women and their families. Bases across the county should be developed that are available for at least 12 hours a day for midwifery led care. A range of different services should also be available at the bases. It is proposed that these bases replace the current model of MLUs for midwifery led care (note in the Birth section that it is proposed that 1 x AMU and minimum 1 X FMU are retained – these may also act as bases for those areas). The same services should be available in each of the bases at times which suit women accessing the services. The location of the bases will be defined by likely population demand and will be easily accessible by car and public transport. Services available will include; - Antenatal care from a midwife - Support from Women's services assistants - Planned antenatal appointments with an obstetrician - Scanning and fetal monitoring for all	The bases will ensure that women have equal access to services across the county. Women will have improved access to a range of services related to pregnancy – they can access them from the same place and can build relationships with peers accessing the services in order to support each other. The sustainability of the service will be improved through more integrated working and improved skill mix within the midwifery led care service. In addition, service availability will be shaped around local demand and activity. The staffing model will require fewer midwives to 'staff' bases, enabling more midwives to be able to flexibly respond to demand. Services will be close to home for women and more joined up. Local services will be available at times that suit the women who use them.

	trimesters (not including labour) - Antenatal day assessment, including CTG monitoring - Support with emotional wellbeing and mental health (action for LMS) - Support with long term conditions during pregnancy - Healthy lifestyle services, including smoking cessation and weight management services (action for LMS) - Information and advice about pregnancy and parenthood including antenatal classes/groups, breastfeeding, baby care and life skills such as budgeting and cooking (some provided by SaTH, some for action by LMS) - Information and advice about birth options - Peer Support (action for LMS) A team of community midwives who have a caseload that is in line with national guidance will support women with planned antenatal care. They will have strong links with local GPs and will be supported by maternity support workers who are able to assist with tasks such as routine phlebotomy, urine testing and weight measurements. Women will have access to midwife advice and support 24/7. This will include advice and support in person, through video call or over the phone.	

	Women and the professionals working with them will have access to up to date information electronically (action for LMS). Peer support networks are in place, where women and their partners are able to link in with others if they want to, to share experiences through initiatives such as drop in 'cafes' and online networks (action for LMS).	
Birth		
Women have a full choice of birth options, delivered through: 1 x consultant led unit 1 x AMU 4 x FMU Home Birth	Women have a full choice of birth options and will be able to give birth at the consultant led unit at Princess Royal Hospital (PRH), at the Alongside MLU at PRH, a Freestanding MLU in Shrewsbury and at home. A community team will be available 24/7 for midwife led births in the midwife led units and at home. There will be improved pathways with maternity services over the border (particularly Wrexham, Hereford and Worcester) to facilitate easier access to services in those areas for women choosing to do so.	Clinical and Financial sustainability will be improved through more effective use of skill mix within teams. Whilst maintaining a full choice of birth options within county, reducing the number of MLUs will enable staffing to be deployed more effectively in line with demand. The current AMU, whilst technically an AMU as it is on the same site as the consultant unit, is not within close enough proximity to the consultant led unit for a greater level of risk to be safely managed in the AMU. Consideration needs to be given to re-locating the AMU closer to the consultant led unit in order to seek to facilitate an increase in midwife led births. SaTH are currently exploring this, as there are other services currently within the women and children's centre at PRH which could potentially be moved to elsewhere in the hospital, enabling the AMU to be

		closer to the consultant unit. The proposed model is designed to increase the number of midwife led births by: Over time, improving the health of women during pregnancy; Changing pathways in antenatal care so that all women receive care that plans for a midwife led birth, unless this won't be safe for the woman or her baby, or she chooses consultant led care for another reason; Enabling women to make a decision about their preferred place of birth later in pregnancy; moving the alongside midwifery led unit closer to the consultant led unit in order for a different level of risk to be safely managed.
Postnatal		
Women have access to inpatient postnatal care in MLUs and as outpatients at home.	A team of community midwives and women's support assistants will be available 24/7 to offer advice and support after the woman has given birth (this will be available from as soon as the mother returns home, or as soon as the midwife who delivered the baby at home has left). This support and advice will be available either in person, through a video call, or over the phone. Bases across the county will be available for at least 12 hours a day for planned midwifery led care. A range of other different services will also be available at the bases. The same services will be	Excellent postnatal care will be available consistently across the county. Clinical and Financial sustainability will be improved through more effective use of skill mix within teams and with staffing configuration better matching service demand.

	available in each of the bases at times which suit women accessing the services. Services available will include; - Postnatal care from a midwife - Support from Women's services assistants - Newborn checks and screening - Drop-in service or planned access during a 12 hour period to enable support, for example with feeding, confidence building, baby care skills - A space for women and their families to reflect on the birth experience - Support with emotional wellbeing and mental health - Support with confidence building and bonding - Support with feeding - Support with long term conditions postnatally - Healthy lifestyle services - Information and advice about parenthood including postnatal groups, infant feeding, baby care and life skills such as budgeting and cooking - Peer Support	

9. Key Documents/Information Sources

The table below lists the key documents/information sources used to inform this review to date.

Key Documents/Information Considered for Phase 1 MLU Review Report	
Document	**Web Link (if available)**
Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)	https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
Implementing Better Births: A resource pack for Local Maternity Systems (March 2017, NHSE)	https://www.england.nhs.uk/wp-content/uploads/2017/03/nhs-guidance-maternity-services-v1-print.pdf
Saving Babies' Lives: A care bundle for reducing stillbirths (March 2016, NHSE)	https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
Saving Lives, improving mothers' care (Dec 2016 MBRRACE UK)	https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202016%20-%20website.pdf
CQC's response to the 2015 survey of women's experiences of maternity care	http://www.cqc.org.uk/sites/default/files/20160125_maternity_survey_2015_cqc_response.pdf
NHS Hospital Episodes Data 2015-16. Summary Report	http://www.content.digital.nhs.uk/catalogue/PUB22384
National Maternity and Perinatal Audit 2017	http://www.maternityaudit.org.uk/pages/home
NICE Guidance, Pathways and Standards	https://www.nice.org.uk
Costing statement: Intrapartum care: care of healthy women and their babies during childbirth Implementing the NICE guideline on intrapartum care(CG190) (NICE 2014)	https://www.nice.org.uk/guidance/cg190/resources/costing-statement-pdf-248729581
The state of maternity services in England Policy briefing (Picker Institute, July 2016)	http://www.picker.org/wp-content/uploads/2016/07/Maternity-services-policy-briefing-V2.pdf
The state of maternity services (Royal College of Midwives 2016)	https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf
Safe midwifery staffing for maternity settings (NICE Feb 2015)	https://www.nice.org.uk/guidance/ng4
Support Overdue: Women's experiences of maternity services (WI and NCT 2017)	https://www.thewi.org.uk/__data/assets/pdf_file/0009/187965/NCT-nct-WI-report-72dpi.pdf
National Tariff Information	https://improvement.nhs.uk/resources/national-tariff-1719/
Compendium of Maternity Statistics, England (HSCIC April 2015)	http://content.digital.nhs.uk/catalogue/PUB17333
Births in England and Wales, Summary Statistics (ONS)	https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummar

	ytablesenglandandwales/previousReleases
Maternity Services Statistics (NHS Digital)	http://content.digital.nhs.uk/maternityandchildren/maternitymonthly
Maternity Services Reports (NHS Digital)	http://content.digital.nhs.uk/maternityandchildren/maternityreports http://www.content.digital.nhs.uk/catalogue/PUB22384
Information received from CCGs and Providers about maternity services in their area	N/A
Information received during service visits to other areas.	N/A
Information from the service provider (SaTH)	N/A
Information held by Shropshire CCG and Telford & Wrekin CCG	N/A
Public Health and JSNA Information (not all available on-line)	https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/data#page/1/gid/1938132997/pat/6/par/E12000005/ati/102/are/E06000051 http://www.telford.gov.uk/info/20121/facts_and_figures/924/population_profile https://www.shropshire.gov.uk/joint-strategic-needs-assessment/
Feedback about maternity services held by Healthwatch Shropshire and Healthwatch Telford & Wrekin	N/A
Feedback about maternity services gathered by local campaign groups	N/A
Feedback about maternity services gathered by SaTH	N/A
CQC Quality Report – Royal Shrewsbury Hospital	http://www.cqc.org.uk/location/RXWAS
Maternity Services Monthly Statistics	http://www.content.digital.nhs.uk/catalogue/PUB24142
Safe, sustainable and productive staffing An improvement resource for maternity services June 2017 (National Quality Board)	https://improvement.nhs.uk/resources/safe-sustainable-productive-staffing-maternity-services/
Note : Shropshire, Telford and Wrekin CCGs are committed to ensuring this review is as open and transparent as possible. Therefore the CCGs will seek to ensure that, where possible and appropriate, any information not currently publicly available, is made publicly available through the CCG websites.	

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