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

Date: 23 July 2019
My Ref:
Your Ref:

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Wednesday, 31 July 2019**
Time: **10.00 am**
Venue: **Quaker Room - Meeting Point House, Southwater Square, Town Centre, Telford, TF3 4HS**

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**
Cllr Karen Calder (Co-Chair)	Cllr Derek White (Co-Chair)
Cllr Madge Shineton	Cllr Stephen Burrell
Cllr Heather Kidd	Cllr Paul Watling
Coptees:	Co-optees:
David Beechey	Carolyn Henniker
Paul Cronin	Hilary Knight
Ian Hulme	Dag Saunders

Your Committee Officer is:

Amanda Holyoak Scrutiny Committee Officer
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AGENDA

1 Apologies for Absence

2 Declarations of Interest

3 Minutes of the previous meeting (Pages 1 - 10)

4 Royal Shrewsbury Hospital Midwifery Led Unit (Pages 11 - 14)

5 Transforming Midwifery Care in Shropshire, Telford and Wrekin : Pre-Consultation Update (Pages 15 - 204)

The final document for this item - Transforming Midwifery Care Consultation Plan – is to follow.

6 Proposed Reconfiguration of Ophthalmology Services (Pages 205 - 248)

7 Co-Chair's Update

SHROPSHIRE COUNCIL,TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on Friday 11 January 201 10.30 am – 1.25 pm in the Shrewsbury Room, Shirehall, Shrewsbury

Members Present:

Shropshire Councillors: Karen Calder (Chair), Heather Kidd, Madge Shineton
Telford & Wrekin Councillors: Derek White (Co-Chair)
Shropshire Co-optees: David Beechey, Paul Cronin, Ian Hulme
Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight

Others Present:

Jo Banks, Women and Children's Care Group Director, SATH
Barbara Beal, Interim Director of Nursing, SATH
Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
Fiona Ellis, Commissioning and Redesign Lead, Women and Children's Services,
David Evans, Chief Officer, Telford and Wrekin CCG
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Nigel Lee, Shrewsbury and Telford Hospital Trust
Rachel Robinson, Director of Public Health, Shropshire Council
Jess Sokolov, Medical Director, Shropshire CCG
David Stout, Accountable Officer, Shropshire CCG
Steve Trenchard, Programme Director, Mental Health Shropshire CCG
Stacey Worthington, Senior Democratic and Scrutiny Services Officer, T&W Council

1. Apologies for Absence

Apologies were received from Councillor Stephen Burrell (Telford and Wrekin Council), Councillor Paul Watling (Telford and Wrekin Council) and Dag Saunders (Telford and Wrekin Co-optee)

2. Disposable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matters in which they had a disclosable pecuniary interest and should leave the room prior to the commencement of the debate.

3. Minutes of the last Meeting

The minute of the meetings held on 3 December 2018, 17 December 2018 and 11 January 2019 were confirmed as a correct record, subject to the following minor amendments:

17 December 2018 – correction of spelling of Sir Neil McKay

11 January 2019 – correction of typographical error in heading

4. Midwifery Services in Shropshire, Telford and Wrekin – Current Position

The Committee asked Jo Banks, Women and Children's Care Group Director, and Barbara Beal, new Interim Director of Nursing, SATH, to provide an update on the current position in Midwifery Services in Shropshire and Telford and Wrekin, following a decision to suspend deliveries and postnatal care at Royal Shrewsbury Hospital whilst renovation work took place.

The Care Group Director explained that:

- The Midwife Led Unit was located in an old building at the RSH site;
- Work was underway with Shropshire Council building regulators to bring the building up to standard;
- The work in the building would cause noise and dust and there would be further refurbishment needed;
- A difficult decision had been made to suspend deliveries and postnatal care for up to 6 months whilst works continued;
- 40 women had been contacted who had been planning a delivery at this location;
- Antenatal care, scanning and early pregnancy services would still be offered
- Phase 2 of the work would involve moving the antenatal care and the base of the community midwives in late August, early September time;
- Work was underway with the Council to find an office type building for community midwives to use as a base
- The home birth offer would remain the same.

Members of the Committee asked the following questions :

Is there capacity to cope with all the home births within the exiting midwifery team? Does the Wrekin Ward at PRH have the capacity needed? How were spikes in MLU births and home births dealt with (particularly in rural areas)

Staffing had been increased in line with Birth Rate Plus, and some new staff had already started. Although the Wrekin Unit had been busy during a temporary closure, the situation was being managed and staff were being moved to where they needed to be. A handover involving all elements of the service took place at 8.30 am every day, there was also a safety huddle at lunchtime with obstetric input.

Are the skills needed available and in the right places?

Barbara Beal, Interim Director of Nursing, explained that she had been in post for less than two weeks but was able to report that the Trust had one of the best preceptorship programmes available. A Development Post was in place to provide support through the preceptorship period. Interviews were imminent for a new Director of Midwifery post, and a number of strong applications had been received.

Would it be possible for the Committee to receive the data on home/hospital births and geographical spread, particularly as there were issues around home births in very rural areas.

The Care Group Director confirmed that it would be possible to share this data and that much of it was already available on the web.

The new Director of Public Health, Shropshire Council referred to public health links with training which would be identified through the LMS.

5. Transforming Midwifery Care Programme Update

Dr Jessica Sokolov, Medical Director, Shropshire CCG, gave a presentation to the Committee on Transforming Midwifery Care in Shropshire, Telford and Wrekin (copy available on the web and attached to signed minutes). The proposed consultation launch was in September and would last for eight weeks.

Members asked the following questions and received responses as follows:

When assessing data regarding locations for hubs, were new build locations in Shropshire and Telford and Wrekin taken into consideration?

Fiona Ellis, Commissioning and Redesign Lead, confirmed that population forecasts and activity modelling had taken new development into account. The implementation of the new model would involve close monitoring to see if activity matched that which had been predicted.

What opportunities would the eight week consultation give to influence decisions made

Dr Sokolov referred to the extensive engagement that had already taken place and explained that some decisions had to be made ahead of consultation to ensure that it would be meaningful. Examples of outcomes that could be influenced by the consultation outcome included the location of the hubs, hub opening hours and how the hub could best serve its community. The final decision would not be taken until the consultation feedback had been conscientiously considered.

What assessment of risk had been made in terms of both local and national recruitment issues?

The model had been designed around a flexible workforce meaning that staff could be deployed in locations as needed. The SATH Care Group Director said that not enough had been invested previously in terms of skills mix, and that many roles did not require midwifery training. Investment would be made in upskilling support workers.

What were the confidence levels in the absolute numbers of staff available, irrespective of band.

The Interim Director of Nursing referred to the national picture and activity underway with commissioners to help Shropshire become a more attractive place to work. Health Education England and NHSI were involved in work on future commissioning numbers and how to model the recruitment and retention of midwives and support workers. This would give the local population more of an opportunity to become part of the workforce. There was a big market to compete against, but once the new model was established, recruitment and retention was not expected to be a problem.

The Programme also sat within the Local Maternity System which had a specific workstream for workforce. Initiatives included training programmes and enabling different professionals to work together. Sustainability would be further strengthened by bringing services together in the new model.

How did flexibility of workforce balance against the desire for continuity, how would this be addressed, particularly in rural areas.

If access to services was difficult isolated expectant mothers might not go, especially in rural areas where public transport was poor.

Continuity of care was defined as a woman and family receiving care from the same team of 6 – 8 midwives. Currently continuity of antenatal and post natal care was good but not as good for the birth. The 2021 national targets were for most women to have continuity of care, this was always a struggle in very rural areas and learning from others including Worcestershire and Powys was being utilised. 24/7 access would be available by phone, face to face and video link would also be built in.

Access in North Shropshire would improve as there was not a Midwife Led Unit currently located there. In the south of the county, the broad geographical area had been impact assessed. A member felt that terminology such as ‘most’ and ‘improvement’ did not give a clear picture and drew attention to the lack of broadband in some rural areas. She wished to know how much the service would improve, who for, and who would it not improve for.

Dr Sokolov acknowledged that broadband and mobile signal was a limiting factor. Further detail on this could be brought back to a future meeting.

The Co-Chair referred to primary care and the shortage of GPs and access issues for patients. He felt the hubs should be based on need and ability to communicate with the local population.

Dr Sokolov acknowledged that many GPs and patients wanted more GP involvement but the capacity was not there. The hubs would be midwifery led rather than GP led.

A Members asked a question about cross border care with other counties, and where they would access antenatal and postnatal care if delivering out of county. Dr Sokolov said there was a need to streamline this.

The Committee asked if it was still the case that two midwives were needed to clean Theatres following surgery. The Care Group Director reported that the Trust had

invested in more scrub nurses to free up midwifery care and had been out to recruitment twice but there was a national recruitment problem.

Members thanked the SATH and CCG Officers for attending the meeting and answering questions.

6. Future Fit

The Committee received the terms of reference and details of the membership of the new Future Fit Implementation Oversight Group. The first meeting was planned for 1 July 2019. The invitation to Joint HOSC co-chairs to attend meetings in the capacity as observers was welcomed.

Debbie Vogler reported that the Independent Reconfiguration Panel was planning to review evidence and hold further discussions with clinicians and other stakeholders. It also intended to visit and a planning meeting and wold identify shortly who it wished to speak with as part of this process.

7. Merger of CCGs

David Evans, Chief Officer, Telford and Wrekin CCG, and David Stout, Accountable Officer – Shropshire CCG, spoke to a briefing paper on the decision by NHS Shropshire CCG and Telford and Wrekin CCG to dissolve the existing two organisations, with a view to creating one single strategic commissioner across the Shropshire and Telford and Wrekin footprint. There was some disagreement between members as to whether the move was a positive one, increasing efficiency, reducing duplication, costs and confusion, or whether it could be seen as a takeover, with Telford and Wrekin becoming exposed to the outstanding historical deficit of Shropshire CCG, and its needs becoming subsumed into those of Shropshire

Members asked the following questions:

- As much joint commissioning was already undertaken, would the main change be in governance structures?
- Would the 20% reduction of running costs be made from staff delivering commissioning of services, or would reduction be limited to back office functions?
- Would care be taken if offering voluntary redundancy that skills that were needed would be retained?
- How would the focus be retained on the differing needs of the very different areas across Shropshire and Telford and Wrekin.
- When would a firm timeline be available, and would this make reference to the Joint HOSC
- Would a staffing reduction of 20% present an obstacle in the shift from transactional to strategic commissioning. Would focus be kept on the capacity to deliver the transformation needed.

In response Mr Stout and Mr Evans explained that:

- No decisions had been taken at present with regard to a voluntary redundancy scheme, the first job was to identify the new structure
- It was recognised that staff might choose to move elsewhere due to uncertainty, and it was important to move fast to remove any uncertainty as quickly as possible .
- The importance of place and varying need across Shropshire and Telford and Wrekin would be critical and would require clarity in the design of commissioning.
- A timeline including a comprehensive engagement plan identifying stakeholders including local authorities, the Joint HOSC, and members of the public would be shared as soon as available.
- conversations were underway with providers and work was on integrated care was ongoing and looking at what could be done a different way by providers.
- It was reiterated that this was not a takeover, but the creation of a new organisation by dissolving two current ones. A significant financial saving would be made by only having one board.
- The ambition was for office HR, finance and payroll functions to combine across the whole of the health economy as well as potentially all public sector organisations to maximise delivery at front end.

It was confirmed that regular updates would be provided to the Committee.

8. Mental Health – Update on the BeeU (0-25 year old) Emotional Health and Wellbeing Service

The Chair welcomed Steve Trenchard, Shropshire CCG Programme Director Mental Health to the meeting.

Mr Trenchard referred to the paper before members which provided the background and events which had led to the current position of the Service. An NHSI Intensive Support Team visit in the summer of 2018 had resulted in a report setting out a number concerns. Senior leadership had held a learning event to look at what had happened, and lessons learnt, particularly in relation to contracts, performance, innovation and relationships.

The paper before the Committee set out a summary of the learning and the draft service delivery model. This incorporated the Thrive principals and a stepped care model – designed to ensure that children and young people could move seamlessly across pathways without the need for multiple assessments. The thrive model would provide effective leadership to the whole system.

A bid had been submitted to establish two teams across the STP area to work with the most vulnerable children in schools. If successful, these would include education mental health practitioners, primary mental health workers, and therapists.

The Co-Chair referred to children who eventually needed specialist education at huge cost, which might have been avoided if earlier help had been provided. A member asked about working with schools which were academies. Meetings were held with Mental Health Leads in schools and investment in Shropshire had been made in family support worker roles.

In response to questions, Mr Trenchard reported that:

- There was a mixed cohort of about 200 children who were waiting assessment although a proportion of these had some initial work completed, such as observations made at school.

- It was not clear what resource for children with autistic spectrum disorders was in the contract envelope when the move was made to the new provider and work was underway to understand this. There was a significant service gap and the need to invest additional resource.

- Public Health data did not provide numbers of children with autistic spectrum disorders and medication for these children would be inappropriate in many cases.
- One concern had been that children taking medication were not receiving physical health checks. Sometimes children did not require a specialist mental health intervention

- schools could refer to the service through completion of a form. There were now eight GPs who had identified themselves as interested in supporting mental health in schools. This had helped to improve relationships and remove confusion around referral.

- Research had shown that there was a huge window of opportunity to prevent progression into adult services, as if referred at the age of 14, 44% of children would go on to progress into the adult service. If coming into the service at the age of 18, almost 80% would then go on into adult services.

- The Shropshire and Telford and Wrekin STP was ranked nationally 42 out of 43 in terms of level of investment in mental health services. In 2010 the CAMHS service had been rated as one of the best, and it appeared that disinvestment in some of the workforce that had caused the problem.

- Most investment was directed towards mental illness rather than prevention and prevention services were being cut due to wider austerity. Social media was causing significant problems and studies had shown the impact of stress caused by social media on the development of young people's brains.

- When the service had moved to the new provider all data had been on paper but had now been transferred to electronic personal records. There were no waiting lists for anxiety and depression, the significant wait was for children with neurodevelopmental conditions. The provider had been asked to break down in full detail where children were at and to contact families to provide an update on progress. There was not an agreement on an interim service to address this which would define what the service would be and when the child was likely to be seen and this was unacceptable.

He went on to outline some of the recent operational improvements and appointments made to stabilise the workforce and reduce the dependency on agency staff.

Members discussed the impact of debt on young people leaving university, and how to address the fundamental problems of anxiety and mental health which were growing all the time. Mental health issues were not visible in very rural areas where sometimes hidden pockets of poverty, caused mental health issues which were kept hidden due to secrecy and shame. Mr Trenchard agreed to make a recent publication on Mental Health and Rurality available.

Members asked if Mr Tenchard felt assured that the necessary leadership was in place to deliver the transformational change needed. He felt that a standardised model across Telford and Wrekin and Shropshire would help . Only now, for the first time, had pathways been clearly described. The large waiting lists and busy nature of the service had led to sickness and transient staff. The required transformation had not happened yet but was currently in progress.

Mr Trenchard reported on the progress made in relation to the recommendations in a Healthwatch report of 2018.

The Committee noted that lack of leadership had appeared to be a significant issue for the service and agreed to return to the issue at a future meeting, with senior leaders present.

The Committee thanked Mr Trenchard for giving the Committee the insight it needed into the complex issues at hand and asked to be kept informed of progress.

9. Joint HOSC Work Programme

It was agreed that the Committee should schedule in dates on a bimonthly basis to start with but to move to monthly meetings if it was felt these were needed and would add value.

Work was needed on prioritising a large number of potential topics and items suggested for future consideration included:

Cardiology waiting times

Incidences of Boarding at SATH

Transforming midwifery Care

0-25 Mental Health Services

Adult Mental Health Services

Future Fit monitoring

Provider Quality accounts

End of Life Strategy

Out of hours neighbourhood work for Powys, Shropshire and Telford and Wrekin

Primary Care Strategy

CCG Merger

Learning Disability Service (written update only unless further work needed)

STP – (it was suggested that there be a special meeting on the STP and Care Closer to Home work).

Chronic pain service

Members noted that the provisional date for the next meeting was Wednesday 31 July.

The meeting concluded at 1.25 pm

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Cover page	
Meeting	Joint Health Overview & Scrutiny Committee
Agenda Item No.	
Paper Title	RSH Midwifery Led Unit
Date of meeting	31st July 2019
Date paper was written	22nd July 2019
Responsible Director	Barbara Beal – Interim Director of Nursing & Quality
Author	Jo Banks – Women & Children's Care Group Director

Executive Summary

Building regulations since 1979 have changed to meet revised principles over the years. The now aged Royal Shrewsbury Hospital Copthorne building does not meet current regulatory standards and needs to be updated. Services therefore need to be relocated whilst building adjustments are made to meet the regulatory requirements of building safety within the copthorne building. This work required is external to the recently refurbished Shrewsbury Midwifery Led Unit (Shrewsbury MLU); however will be in the locality.

This paper provides the members with information regarding the temporary suspension of intra-partum care at RSH MLU and the current proposed relocation of ante-natal, community services and early pregnancy assessment services located within the RSH MLU with associated approximate timescales.

Previously considered by	

The Board is asked to:			
☐ Approve	☑ Receive	☐ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☐ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports*
	☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare
	☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care
	☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities
	☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions

	☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	Risk 1204: *If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage*

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	No

Situation

The purpose of this paper is to inform the committee of the maternity services provided from Shrewsbury MLU.

Building regulations since 1979 have changed to meet revised principles over the years. The current building does not meet modern regulatory standards and therefore needs to be updated. Services therefore need to be relocated whilst building adjustments are made to meet the regulatory requirements of building safety within the copthorne building (external to the Shrewsbury MLU).

Progress

Phase 1 -
The inpatient (intra-partum) care element of the service has been temporarily suspended on the 10th June 2019 (for up to 6 months) whilst phase 1 planning and building work commences within the copthorne building. This is to ensure that the experience of birthing women will not be affected by construction noise and disruption. The Shrewsbury MLU birth activity of up to 10/month will be relocated to Wrekin MLU at Princess Royal Hospital.

Phase 2 -
As the building adjustments progress; the non-inpatient (community) element of maternity services provided within the Shrewsbury MLU "foot print" (including midwifery and obstetric antenatal care, community midwifery teams, EPAS and Scanning) will need to relocate. It is estimated that this is not required to be enacted until late August to mid-September 2019.

The environment for the relocation of all community midwifery services within the Shrewsbury area is now confirmed; these are as follows:

1. Relocate midwifery and obstetric antenatal care, EPAS and Scanning to the "old" fertility service area within the main Shrewsbury hospital. This is reliant on EBME moving out of the area once the basement accommodation is available to them. This is estimated to take up to 6 weeks within the Phase 1 timescales. The old fertility service area will then have to be refurbished to accommodate the maternity services described above.

2. Relocate community midwifery teams (up to 30 staff) to alternative accommodation. This is currently identified as the Mytton Oak building on the main Shrewsbury Hospital site. Estates are working with the midwifery team to scope the refurbishment required and timescales to re-locate.

Conclusion
The environment for the relocation of non-inpatient (community) elements of maternity services provided within the Shrewsbury MLU "foot print" (including midwifery and obstetric antenatal care, community midwifery teams, EPAS and Scanning) is now confirmed.

An estates and clinical task and finish group are meeting fortnightly (next meeting 29th July 2019) to scope and assess timescales and work required; with subsequent project planning, timescales and oversight by the Interim Head of Estates. This is executively led within the Trust by the Director of Corporate Governance.

Recommendation
The committee are asked to receive the report.

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Transforming Midwifery Care in Shropshire, Telford & Wrekin

Shropshire, Telford and Wrekin Joint Health Overview and Scrutiny Committee

31st July 2019

Title of the report:	Transforming Midwifery Care in Shropshire, Telford and Wrekin : Pre-Consultation Update
Responsible Director:	Dr Jess Sokolov. Medical Director
Author of the report:	Debbie Vogler Associate Director Fiona Ellis Programme Manager LMS
Presenter:	Debbie Vogler/ Jess Sokolov

Summary Report

The purpose of the report is to provide Joint HOSC with additional information following the presentation given on Monday 24th June.

The following DRAFT documents are provided:

- Draft Pre-consultation Engagement Report
- Draft Seldom Heard Groups Pre-consultation Engagement Report
- Draft Equality Impact Assessment

It should be noted that these documents are in draft form and will continue to be updated as required.

Pre-consultation engagement report

This document summarises the engagement that has been carried out since 2017 around the proposed reconfiguration of midwifery led maternity services in Shropshire and Telford and Wrekin until early June 2019. It also outlines how the proposed service model responds to the feedback received.

It includes feedback from engagement with:

- National bodies, organisations and individuals
- Neighbouring NHS organisations
- Clinicians
- Non-clinical staff
- Politicians/MPs
- Councils
- Healthwatch
- Voluntary and Community Sectors
- Patients
- Other Stakeholders

Seldom Heard Groups Pre-Consultation Engagement Report

Building on the previous general engagement work in 2017 and 2018, a pre-consultation engagement exercise took place with seldom heard groups in May/June 2019. The purpose of this engagement was to obtain and listen to the views of people who don't normally engage with the NHS to ensure that we were aware of any particular impacts on any particular groups of people that might alter the proposed service model for midwifery-led maternity services.

As we are discussing a proposed new service model for midwifery-led maternity services, our main target audience was women who had recently had a baby or those who were likely to have a baby in the near future. These groups were further sub-divided to include:

Age

- Teenage women
- Older women (age 35+)

Gender

- Women

Sexual orientation

- Lesbian and bisexual women of childbearing age

Disability

- Women of childbearing age with a physical disability
- Women of child-bearing age with a learning disability
- Women of child-bearing age with a mental illness
- Women of childbearing age with a sensory impairment
- Women of childbearing age with a long term condition

Race

- BAME women of childbearing age (particularly those born outside the UK and African, African Caribbean, Indian, Bangladeshi and Pakistani)
- Gypsy and traveller women of childbearing age
- New migrants/asylum seekers of child-bearing age
- Non-native speakers of English e.g. Polish women of childbearing age

Religion

- Amish/Mennonite women of childbearing age

In total we spoke to over 170 women of childbearing age as well as some partners and families. These women live in different areas of Shropshire and Telford and Wrekin, including rural areas and areas of deprivation. For example: Shrewsbury, Telford, Oswestry, Newport, Whitchurch, Craven Arms, Ludlow, Bridgnorth, Wellington, Shifnal, Broseley, Wem, Pontesbury, Uffington and Hodnet and their surrounding areas and villages. We also spoke to a small number of women from Powys who were receiving maternity services in Shropshire.

<u>Equality Impact Assessment (EIA)</u>

The EIA sets out to address the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are

possible?

We have identified that certain groups of people do have different needs, experiences, issues and priorities in relation to maternity services, and specifically, midwife-led services. However, overall, due to the community model that is being proposed and local services being available depending on the needs of women, there will be a positive impact on most women. The proposed model will also promote equality across the whole of the county as women will be able to generally access the same level of service, particularly ante- and postnatal care wherever they live. This isn't always the case currently. There will possibly be a negative impact on women who are currently living near to the existing rural MLUs where they can give birth, if they are no longer able to do so and therefore have to travel further. This will, however, mainly impact on women who are classed as low risk as anyone who has certain risk factors (like a long term condition, or is particularly young or old) would already have to travel to give birth in the consultant-led unit. In addition, if the hubs are not located in the same locations as the existing MLUs, some women might need to travel further to access some services.

Recommendations:

1. That the draft pre-consultation engagement report, pre-consultation seldom heard groups engagement report and equality impact assessment are noted.
2. That updated versions are brought to Joint HOSC as required.
3. That the access impact assessment is brought to Joint HOSC in September 2019.

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Transforming Midwifery Care
in Shropshire, Telford & Wrekin

Midwifery Led Service Review in Shropshire, Telford and Wrekin

Draft pre-consultation engagement report (2017 – June 2019)

1. Introduction

This document summarises the engagement that has been carried out since 2017 around the proposed reconfiguration of midwifery led maternity services in Shropshire and Telford and Wrekin until early June 2019. It details how we have developed our proposed model and our consultation based on feedback from stakeholders, patients their families and carers, members of the public, clinicians and GPs.

Led by the Midwife Led Unit Review Programme Board, as well as women and their families, a range of key professionals have been well engaged throughout the review, including:

- Senior midwifery and obstetric staff
- Front line midwifery staff
- CCG commissioners
- Public Health commissioners
- Healthwatch

Our proposed model has been developed by co-production with both clinicians and local women and their families. We have also engaged with women belonging to one or more of the nine protected characteristics and have ensured that their views have been taken into account.

We have spoken to national clinical experts and have reviewed clinical models in other areas so that we can learn from best practice and what is working well and what isn't working so well in other midwifery led services.

Full details of the engagement with our different stakeholder groups are outlined below. This includes the feedback they have given and how this has influenced the development of our proposed model.

2. Stakeholder engagement

2.1 Engagement with national bodies, organisations and individuals

We have sought the views of a number of national organisations and individuals from outside Shropshire and have incorporated their feedback in the development of our proposals. This has included NHS England through its assurance process as well as Baroness Cumberlege, the peer who led on Better Births and who has visited the county on a couple of occasions to discuss maternity services. Professor Denis Walsh, Associate Professor in Midwifery at the University of Nottingham and expert midwife, Sascha Wells Munro, have also provided very helpful information in relation to research findings and national best practice.

We have received various communications from the Midwifery Unit Network, including letters, freedom of information requests and telephone conversations have also taken place with the Executive Manager of the Network.

We have also considered the findings of the Royal College of Obstetricians and Gynaecologists' review in developing our proposed service model:

https://www.sath.nhs.uk/wp-content/uploads/2018/07/12-RCOG-Report.pdf

In addition, the Acting Assistant Director of Nursing NHS England, North Midlands sits on the Midwife-led Unit Review Programme Board. More details of these meetings, conversations and correspondence, including any feedback given and how we have used this feedback, can be found in Appendix 1.

Details of our engagement with national charities can be found in section 2.8 and Appendix 8 below.

2.2 Engagement with neighbouring NHS organisations

Providers and commissioners of maternity services in neighbouring areas, particularly in Wales and Worcestershire, have been engaged during the pre-consultation phase to hear their views about our proposed model and also to review how services are delivered in their areas. Please see Appendix 2 for more information about the engagement that has taken place.

2.3 Engagement with clinicians

Significant engagement has taken place with clinicians locally to develop the proposed clinical model. This has included GPs, midwives (including expert midwives), women's support assistants, obstetricians, neonatal nurses and consultants and healthcare assistants. Clinicians from different clinical backgrounds took part in the engagement delivered by external organisation, the ELC Programme, in 2017. A broad mix of clinicians based in different parts of the county have also been involved in a number of stakeholder meetings and workshops, including the options appraisal workshops.

Clinicians including GPs and secondary care clinicians have also been involved due to their membership of the CCG governing bodies and also the Midwife-led Unit Review Programme Board. The following staff have attended and have provided feedback at the programme board meetings:

- Senior midwifery, neonatal and obstetric staff from The Shrewsbury and Telford Hospital Trust
- Heads of Nursing and Clinical Chairs at Shropshire and Telford and Wrekin CCGs
- Frontline midwifery staff
- Health visiting staff
- Network Manager/Lead Nurse Staffordshire, Shropshire & Black Country Neonatal Operational Delivery Network
- Acting Assistant Director of Nursing NHS England, North Midlands

At the outset of the review, the CCGs approached NHS England for recommendations of expert midwives who have experience of best practice nationally and would be able to inform thinking as a new model is developed. As a result of this an expert midwife was appointed to provide specialist midwifery insight at every stage of the development of the model. In addition, discussions took place with midwifery leaders in other areas, to understand the range of models of midwifery led care successfully operating in other areas.

A clinical review panel (West Midlands Strategic Clinical Senate) considered the proposals at a Clinical Senate on 28th March 2018 (Stage 1) and 4th June 2018 (Stage 2.) The findings of the clinical review panel are provided below. The full report can be found here: http://www.wmscnsenate.nhs.uk/files/8615/3553/8048/Shropshire_Midwifery_Led_Unit_Report_-_Final.pdf

> *"The panel concluded clearly that the proposals were with merit, and supported their implementation, with a range of observations and further consideration …. [The panel] believe that, once appropriately implemented, the proposals will contribute to the provision of safe, effective and sustainable care for expectant mothers, their babies and their families across Shropshire and beyond."*

More details about the involvement of clinicians in the review process and the development of the proposed clinical model can be found in Appendix 3.

2.4 Engagement with non-clinical staff

Staff working in our two local clinical commissioning groups, Shropshire CCG and Telford and Wrekin CCG, and our local provider organisations, including the Shrewsbury and Telford Hospital NHS Trust, have regularly been kept up-to-date about the midwife-led unit review through the organisations' normal communications channels such as e-newsletters and face-to-face staff briefings.

Regular updates have also been given at Board meetings where directors and other members of staff have been present. Some non-clinical staff have also taken part in the engagement work that has taken place with staff working in or associated with the midwife-led units. Commissioners of maternity services, communications and engagement staff, the local maternity system programme lead, the Maternity Voices Partnership development co-ordinator and a project support officer are all involved in the Midwife-led Review Programme Board. More information about engagement with non-clinical staff can be found in Appendix 4.

2.5 Engagement with Politicians/MPs

Our local MPs in Shropshire and Telford and Wrekin are:

- Shrewsbury and Atcham – Daniel Kawczynski

- North Shropshire – Owen Paterson
- Ludlow – Philip Dunne
- The Wrekin – Mark Pritchard
- Telford – Lucy Allen

Regular meetings take place with the accountable officers of the two CCGs in Shropshire Telford and Wrekin and local MPs to update them on the work of the CCGs and any projects of interest. This has included discussions about local maternity services including midwife-led services. The clinical chair of the Local Maternity System (LMS) has also attended meetings to discuss the midwife-led service review with MPs and has had a separate meeting with Philip Dunne in his Ludlow constituency. However, as no record of discussions at these meetings is kept, we are unable to provide further details on any feedback given and how this has influenced our proposals.

A written briefing was circulated to all MPs in November/December 2017, which talked about the outcomes from the engagement work and also the next steps.

In addition, the programme manager has attended a number of Oswestry Health Group meetings, chaired by Owen Paterson, to discuss the review.

2.6 Engagement with Councils

Joint Health Overview and Scrutiny Committee and Health and Wellbeing Board meetings at our two local authorities in Shropshire and Telford and Wrekin have been regularly attended to discuss the midwife-led service review. In addition, members from these bodies and representatives from the Public Health teams at the two councils have been involved in a number of meetings and workshops, including the options appraisal workshops. Public health representatives from both Shropshire Council and Telford and Wrekin Council are members of the Midwife-led Unit Review Programme Board and they are able to give any feedback they have at these meetings. Public health representatives have also participated in CCG board meetings. More details of engagement with our two local councils can be found in Appendix 6.

2.7 Engagement with Healthwatch

We have two local Healthwatch organisations – Healthwatch Shropshire and Healthwatch Telford and Wrekin. Representatives from both organisations have regularly been invited to stakeholder meetings and workshops and they have participated in the options appraisal process. They have also been involved through their participation in local authority meetings including Health Overview and Scrutiny Committee and Health and Wellbeing Board meetings.

Both Healthwatch organisations have also had representation on the Patient Reading Group. The purpose of the group is to provide a patient and public perspective on the development of the consultation plan and the materials to ensure that all relevant groups are being communicated and engaged with and that the language used in all communications is easy to understand.

Healthwatch Shropshire and Healthwatch Telford and Wrekin are both members on the Midwife-led Review Programme Board and their views have been included in the process by attendance at these regular meetings.

A letter submitted by Healthwatch Shropshire in December 2017 highlighted the following concerns:

- Reduction of inpatient postnatal care
- Safety of home birth service and availability of midwives
- Lack of parity of services in the north-east of the county

2.8 Engagement with the voluntary and community sectors

Local voluntary and community organisations from Shropshire and Telford and Wrekin have been updated and had an opportunity to give feedback on the review of midwife-led services through their involvement in a number of meetings and at workshops and events. This has included the Joint Health Overview and Scrutiny Committee for both councils and the Health and Wellbeing Board at Shropshire Council and Telford and Wrekin Council. Representatives have included the following organisations: Shropshire Partners in Care, Age UK, the Shropshire Voluntary and Community Sector Assembly (VCSA) and the Chief Officer Group for voluntary sector organisations in Telford and Wrekin.

In December 2017, Birthrights, a national charity “dedicated to improving women’s experience of pregnancy and childbirth by promoting respect for human rights” expressed some concerns about the midwife-led unit review to Shropshire CCG:

- Safety and increase in anxiety for women who have to travel further in labour and to unfamiliar surroundings
- Local hubs not offering births or immediate postpartum facilities
- Removal of patient choice
- Delays in midwives attending home births
- Weak commitment to MLU births

In December 2017, AIMS (Association for Improvements in the Maternity Services) wrote to key professionals in Shropshire, Telford and Wrekin asking for a case for change for rural midwife led units to be considered.

2.9 Engagement with patients

Local patients and the public have been fully involved in the review of midwife-led services in Shropshire, Telford and Wrekin since it started in 2017. An external company, The ELC Programme, which specialises in delivering engagement activities, was commissioned to obtain the views of pregnant women, women who have recently given birth and their partners from across the county. Much of the feedback from women living in rural and urban areas about what they value is very similar, for example:

- Postnatal care, particularly inpatient care in MLUs
- Continuity of carer
- Making friends with other mums

Women in rural areas, in particular, expressed concern about travelling while in labour, deliveries before arrival and also travelling back home again if they were advised that they weren't yet close to giving birth.

The primary target audience for our engagement work has been women of childbearing age (16-44), women who have recently given birth and their partners and families. However, other people not belonging to one of these groups have also had an opportunity to have their say through a number of meetings, workshops (including in relation to the options appraisal) and events and through written correspondence. Members of the public have also been able to ask questions and raise concerns at public CCG board meetings.

Other concerns expressed by members of the public included having enough midwives to cover home births, the increased risk for mothers and babies, the capacity of other maternity services, increased pressure on the ambulance service and the quality of the service.

We also completed a specific piece of pre-consultation engagement work with people belonging to one or more of the nine protected characteristics under the Equality Act 2010.

Outcomes of the pre-consultation engagement with seldom heard groups are included within a separate report.

Women of child-bearing age and/or women who have recently given birth from across the county have also been involved in the options appraisal process and in the Patient Reading Group. The purpose of this group is to provide a patient and public perspective on the development of the consultation plan and the materials to ensure that all relevant groups are being communicated and engaged with and that the language used in all communications is easy to understand.

We also had a patient representative on the Midwife-led Review Programme Board.

A summary of the feedback received through all of these methods is outlined in the table in Appendix 9.

In addition to the new information gathered, the following sources of existing patient feedback have been used to inform the proposed new model of care:

- 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)

The majority of feedback received from patients in relation to MLUs has been positive.

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.

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 three 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.

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.

2.10 General stakeholder engagement

Many of the workshops and events organised as part of the review of midwife-led services in Shropshire, Telford and Wrekin have brought different stakeholders together, including patients and the public, clinicians and other stakeholders. It has therefore not always been possible to attribute specific feedback to specific groups attending these workshops and events although we have endeavoured to do so wherever possible. These have been highlighted in the tables relating to the different stakeholder groups above.

A launch event for the midwife-led service review took place on 7th September 2017. This table summarises key elements of improvement feedback and responses:

You said	We did
Maximise best practice where it already exists	Once the service model is better defined, we will undertake reviews to identify best practice to build on
FNP should be within health visiting service. They are not a specialist midwife.	Once this part of the review is completed, we will revisit the need to engage with health visitors. The report and slides will be amended to recognise this error
Social care needs to be involved in this	The commissioning team will make links with social care
Expand the breadth of participation	The engagement team will revisit novel ways to

	engage with the stakeholders within the maternity community
Quieten loud voices in the room	Lead facilitators and table top facilitators will ensure that participants are reminded of the understandings and manage participation so everyone feels they are heard
Noise impacts on some peoples' concentration	This will be recognised upfront so people expect noise from children in the room and agree to work with it

Following the launch event, a series of co-design workshops were organised 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. The ideas described below were generated at a series of co-design workshops held across the county in September/October 2017. The table below summarises the locations and attendance for each co-design workshop:

Co design workshops	
Venue	**Attendance**
5/10/17 Shrewsbury (day time)	26
14/9/17 Oswestry	30
18/9/17 Ludlow	28
20/9/17 Bridgnorth	22
5/10/17 Shrewsbury (evening)	6
25/9/17 Telford	12
22/9/17 Market Drayton	7
Additional session Shrewsbury (evening)	1

The shared ambition developed through the co-design workshops responded to and built on the insights generated from in depth interviews and semi-structured feedback provided by over 100 families and over 80 frontline staff – mainly midwives and women's care support assistants in July 2017. The key elements of the shared ambition developed through the co-design workshops are described below.

The importance of healing history

Participants recognised that there has been a difficult shared history over the last few months, with significant loss of trust in the "system". 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.

Overarching principles

Participants identified seven 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
- 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

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 the previous engagement work.

Participants at the co-design workshops wanted 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:

- Midwife-led care to support families to thrive
- Midwife-led care that is relationship-centred and builds community
- Midwife-led care responds to a 'family centred plan'

- Midwife-led care responds proactively and equally to physical and mental health issues
- Midwife-led care is provided in the heart of the community
- Support early in pregnancy
- Great perinatal mental health support
- Review risk classifications and management of high risk women
- A safe, familiar place to give birth
- Great postnatal care for everyone
- Well supported, trained staff; new workforce models
- Improved communication and joint working
- A model built on evidence and best practice
- New outcomes and measures of impact

More detailed feedback from these co-design workshops, and the engagement with staff and patients that preceded them, can be found at: https://www.shropshireccg.nhs.uk/media/1059/final-insight-report.pdf

From the various workshops and interviews that took place in 2017, led by ELC Works, the characteristics that participants felt make up good maternity care in Shropshire, Telford and Wrekin were 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 breastfeeding
    - 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 who have 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.

These design principles have been used to build the proposed future model for midwife-led services in Shropshire, Telford and Wrekin.

Appendices

Appendix 1

Engagement with national bodies, organisations and individuals

Name/type of meeting	Date	Location	Attendees	Summary of feedback	How did feedback influence the proposals or the process?
Telephone conversation and emails with Professor Denis Walsh, Associate Professor in Midwifery, School of Health Sciences, University of Nottingham	July 2017-February 2018	N/A	Dr Dennis Welsh/Fiona Ellis	The more viable smaller units work well as they are used for other purposes such as clinics, education etc and then opened up for births as required – achieved through caseloading/on-call arrangements. Few and increasingly fewer FMUs have postnatal inpatient facilities. Awareness-raising/constant engagement with women and their families about what FMUs are and what they can deliver is key in getting them used as much as possible.	Awareness-raising and constant engagement with women about midwife-led birth options will be delivered in the new model in partnership with the Maternity Voices Partnership. This work has already started through the Local Maternity System. The options appraisal process included service configurations in which the proposed maternity hubs would offer births on an 'on call basis'. Travel times and access implications have

				The vast majority of FMUs have midwives and MSWs, smaller FMUs (<100 births/year) more likely to have community midwives who go with women into the FMU for labour so don't have core midwifery staff in FMU +/- MSW as core staff in FMU. Suggest you contact Portsmouth who have this model. Best functioning AMUs always have core staff and some have slow rotation of Obstetric Units midwives through. Within 30 minutes travel time is more common for women to access MLUs or locations where additional clinics are delivered. Assume that all women will have a midwife led birth unless they 'opt out.' Have a target for midwife-led unit and homebirths. 35% of all births should be an aspiration	been taken account of through the options appraisal process, including through and access impact assessment. The proposed new model of care includes a midwife-led birth as the 'default' position unless there is a clinical reason or other reason why this is not appropriate for/preferred by a woman accessing maternity services. We have considered other models operating elsewhere, including Portsmouth. A target for increasing midwife led births is included within the Local Maternity System programme. Through increasing the health of women in pregnancy and

				and 30% achievable in the medium term. Have AMU immediately adjacent to CLU. Give it some core midwifery staff, with clinical lead who is not line managed by the labour ward. Staff it from community as well, caseload if you can or failing that, regular weekly shifts. Don't staff it with labour ward midwives. Delay decision about place of birth but flag it up at booking with a recommendation if low risk so women are introduced to the idea. Try and get women to visit the midwife-led units during pregnancy. The following are important: - Full choice of options available - Pathway of low risk - Continuity	improving the sustainability and attractiveness of midwife led units, the proposed model of care will increase midwife led births. The proposals include the need for the alongside MLU to be immediately adjacent to the consultant unit. This will be delivered through 'Future Fit'. The midwife-led units will have core staffing, linked to the consultant unit and community teams in order to deliver continuity of carer. Pathways have been changed so that the decision about place of birth is not made until later in pregnancy. A full choice of birth options has been retained. Low risk pathway is the 'default' in

				Particularly for first time mums, continuity of carer in home visits postnatally is really important. There is a trend for shorter and shorter inpatient postnatal stays. Every Trust in England should have an FMU and an AMU. In our report we are not commenting specifically on how many FMUs a Trust should have.	the proposed new model. The proposed staffing model will deliver continuity of carer.
Letter to Dr Simon Freeman (Accountable Officer, Shropshire CCG) from Midwifery Unit Network	7 December 2017	N/A	Mary Newburn, Executive Manager	Concern about closure of MLUs in Ludlow, Bridgnorth and Oswestry. Dismayed and perplexed by data showing that births in MLUs in Shrewsbury and Telford have been declining. Suggests lack of clinical leadership for maternity services and either ignorance of evidence or lack of commitment to provide evidence-based services. This works against the expressed needs of women and families.	No decision has been made on the future model of midwifery led care. The decision to carry out a review of the midwifery led services was taken after our local Trust provider, NHS Shrewsbury and Telford Hospital Trust, raised concerns about staff levels stretched across multiple sites. Our proposals will enable woman-centred, responsive,

				Maternity services must be managed so they are woman-centred, responsive, safe and personalised in line with national maternity policy, clinical guidance from NICE and the recommendations of the NMPA.	safe and personalised care to be delivered in line with national maternity policy, clinical guidance from NICE on choice of place of birth for women (CG190), and the recommendations of the NMPA. This is an evidence-based review, which has also been supported by an expert midwife specialist recommended to us by NHS England. The proposed new service model for midwifery led care will meet the needs of the population of Shropshire, Telford and Wrekin including rural communities and will fulfil the requirements of Better Births. Our service model proposes to retain a full choice of

					birth setting as defined in Better Births (Consultant led unit, alongside MLU, freestanding MLU and home birth) and this is currently only offered in 22% of trusts and boards (as reported by NMPA 2017).
Freedom of Information Requests from Midwifery Unit Network	January - February 2018	N/A	Mary Newburn, Executive Manager	Asked for copy of review carried out by midwifery expert and person specification for this role including their knowledge of rural maternity services and FMUs. Asked for detailed information on advice sought from "nationally recognised and respected associate professor of midwifery" and his response. How many women gave birth in 2013/14/15/16 and 17 who were registered with a GP in and around Ludlow, Oswestry, Bridgnorth, Shrewsbury and Telford? How many of these women, in each year and place, were assessed as having a straightforward pregnancy with	Detailed feedback provided as requested.

				low likelihood of complications?	
Email to Dr Simon Freeman (Accountable Officer, Shropshire CCG) from Midwifery Unit Network	10 February 2018	N/A	Mary Newbury, Executive Manager	Commendable plans to address expressed needs of women by providing services close to home, including realistic access to home birth services across the county, better cross-boundary working and access to services in Wrexham, Stoke and Hereford, as women prefer or need them. An increase in home births will of course require the midwife capacity and responsive on-call system to make this possible. Not clear, based on recent trends in Shropshire, how the proportion of women giving birth in midwifery-led settings will improve and at what price. ***'Increasing access to midwife-led birth settings is a national priority'.*** Concern about lack of investment in facilities and staffing for midwifery birthing services. Misguided to consider closing FMUs: evidence shows excellent outcomes for mothers and babies.	In our LMS plan, we have set a target to increase midwife led births to 25% by 2021, and plan to further increase to beyond 30% in the years following. We have taken the decision to set realistic and achievable targets, and to reset them as we achieve them. Whilst not specifically detailed in the model overview, Denis Walsh's advice regarding postnatal support and promotion of MLUs would be expected to form part of the service delivery plan from the provider and will be included once this more detailed service model is in place. The proposed model will increase midwife led births and "create and support the community to promote a positive narrative around MLU births."

				Evidence suggests it would be in the public interest and financially viable to run a midwifery birthing facility from each of the five sites. Take up of home births and MLU care is affected by the information women are given and by support from commissioners and midwifery leadership. Decline in MLU births may reflect management issues and a lack of corporate confidence in delivering for safety and quality in MLUs.	We are confident that these measures will help us meet and exceed our targets for midwife led deliveries,and reflect what we heard during our extensive engagement programme. We are also confident that by creating a model which is sustainable and deliverable, we will be able to improve confidence in the reliability of the service, which should further lead to increased usage.
Telephone conversation with Midwifery Unit Network	9 March 2018	N/A	Mary Newbury, Executive Manager Fiona Ellis, Programme Manager	Sad that we're seen to be 'closing' MLUs but understands how our proposals are a positive move forward in providing, sustainable, reliable services close to home that offer everything that Better Births suggests we do.	Birth facilities in hubs were considered during the options appraisal process. Delivery of Better Births objectives was a criterion in the options appraisal process.
NHS England visit – Baroness Cumberlege, Independent Chair, National Maternity	26 March 2018	Shrewsbury	Baroness Cumberlege NHS England	Feedback from Baroness Cumberlege - Concerns raised about:	

Review			Women who have used services Campaigners Healthwatch Midwives SaTH Chief Exec, Director of Nursing, Head of Midwifery and Clinical Director for Maternity T&W CCG AO and Executive Nurse Shrops CCG AO and Director of Nursing Shropshire CCG, Clinical lead for MLU Review LMS Programme Manager	Not clear how the proposed model will address the financial challenges. Unclear how continuity of carer would be achieved within the proposed model. On-demand staffing model for midwifery led births	This process has been driven by clinical sustainability and gaining the best possible outcomes for mothers and their babies and not by finance. Once our future model has been agreed, following consultation with our population, we will be ensuring our workforce is aligned to deliver continuity of care. This has been explored, however, having considered how such a model works in other areas and our local geography, demographics and demand, it was concluded that it is not appropriate for birth provision to be included in the maternity hubs.
NHS England Sense Check	18 October 2018	Rugeley	Representatives from:	Describe the hub model and the wider service offer to women	All of the feedback will be addressed in the Pre-

			NHS England Shropshire CCG Telford and Wrekin CCG Shrewsbury and Telford Hospital NHS Trust	and families clearly. Evidence the choice of location of the community hubs and their purpose as opposed to the current provision. Clarify the change in the resource base and that the envisaged service model is deliverable within the proposed resource envelope. Clearly demonstrate that there is sufficient bed capacity to manage birth through the revised clinical model. Clearly set out the current and future workforce assumptions and how these will improve the current workforce inequalities. Be clear on what is being consulted on, recognising the nature and type of locally accessible services that will be offered to women and families. Show examples of how engagement has shaped your	consultation business case.

				proposals. Consider the views of wider stakeholders and how the voluntary sector can contribute. Ensure local GPs have been involved in shaping the proposed model and the level of their support, in particular those practices close to the current midwifery led units. Demonstrate how patient choice has helped influence the development of the proposals. Financial information needs to be clear and consistent, comparing current cost with the cost of the proposed service on a like for like basis. Need to clearly articulate the level of funding through tariff and the system opportunity saving and a clear commitment for the system to fund the new model of care. The financial model needs to better articulate the overall cost/ benefit from the commissioner view in terms of	

				the investment maintained and the services offered or indeed improved within the financial envelope. Describe the impact on travel times for patients and families including the options on alternative transport opportunities and any potential mitigations. Demonstrate how engagement with the nine protected characteristics has shaped the proposals. Describe the impact (if any) on the other services run from the MLU sites. Clearly articulate the impact on **all** providers, including the impact on both the workforce and other services that will remain with the providers. Identify further actions to mitigate these impacts.	
NHS England visit – Baroness Cumberlege,	5 February 2019	Telford	Representatives from:	How does the proposed model meet the	The proposed new model includes more effective

Independent Chair, National Maternity Review			NHS England Shropshire, Telford and Wrekin STP Shropshire, Telford and Wrekin LMS Shropshire CCG Telford and Wrekin CCG Shrewsbury and Telford Hospitals NHS Trust	aspirations of women and make the best use of funds and assets? How will the model enable women to have continuity of carer?	deployment of staff in line with demand. It includes an increased skills mix, and more Maternity Support Workers providing a broad range of care, support and advice for women. This will enable midwives to focus on the care that requires their expertise. The CCGs will continue to pay the nationally set tariff and will endeavor to make sure that this model improves both financial and workforce efficiency for the whole system. The staffing ratios included for the community midwifery team in the proposed new model are in line with continuity of carer guidance and good practice. The Shropshire, Telford & Wrekin LMS has secured additional funding to support the continuity of carer agenda

				How have options including birthing facilities at the hubs been considered?	and is working in partnership with North West London LMS to increase the pace and scale of implementation. From the outset, as part of the research element of this review, a broad range of models of midwifery led care were explored, including 'open on demand' models. The Powys and Cheshire and Merseyside models were included amongst others in this research.
Telephone conversation with expert midwife (NHSE/NHSI) Sascha Wells Munro	11th April 2019	N/A	Fiona Ellis/Sascha Wells-Munro	Supportive of model and confirmed it is in line with good practice. Other feedback: Band 2 and 3 staff in the hubs should have a first on call midwife to contact in an emergency. Need clear boundaries about the length of time women can	We will ensure this is built in to the pathways. Agreed.

				stay in an MLU/hub after birth. The postnatal pathway needs to be clearly described to show what services will be available.	We will make sure that the postnatal pathway is clear at the point we go out to consultation in order to give women and their families clear information with regards to what will be on offer.

Transforming Midwifery Care
in Shropshire, Telford & Wrekin

Appendix 2

Engagement with NHS organisations in neighbouring areas

Name/type of meeting	Date	Location	Attendees	Summary of feedback	How did feedback influence the proposals or the process?
Betsi Cadwaladr University Health Board, Wrexham	10th November 2017	Wrexham	Fiona Ellis and Fiona Giroud, Director of Midwifery and Women's Services, Betsi Cadwaladr University Health Board	Need to ensure that we understand the impact any potential service changes may have on the number of Shropshire women accessing maternity services at Wrexham Maelor Hospital. Need to strengthen pathways between Shropshire maternity services and Wrexham maternity services in order to make it easier for staff working in Shropshire and Wrexham maternity services as well as for Shropshire women accessing services in Wrexham.	Activity levels and potential changes have been explored and are not considered to be likely to impact significantly on Wrexham maternity services. The importance of clear pathways with other areas is acknowledged in the proposed service model.
Betsi Cadwaladr University Health Board, Wrexham	November 2017 – February 2019	N/A	Fiona Ellis and Fiona Giroud, Director of Midwifery and Women's Services, Betsi Cadwaladr University Health	Concern about increase in activity due to closure of Oswestry MLU.	An increase in capacity is not reflected in the data received by Shropshire CCG. Potential data quality issues need to be resolved.

Various telephone conversations			Board		Meeting to discuss to be organised. When the consultant-led unit moves to Shrewsbury, there may be a decrease in women going to Wrexham.
Worcestershire Acute Hospitals NHS Trust – Visit to Meadows MLU	13th June 2017	Worcester	Cathy Garlick, Worcester Acute Trust Divisional Director of Operations/Fay Baillie, Worcestershire Acute Trust Divisional Director of Nursing and Midwifery/Fiona Ellis	Discussion around staffing models that could be considered and facilities that could be available.	Consideration of Worcester MLU model as an option for delivery in Shropshire.
Powys Teaching Health Board	To be updated	To be updated	To be updated	To be updated	To be updated
Powys Teaching Health Board - Visit to Welshpool Birth Centre	5th May 2017	Welshpool	Cate Langley, Head of Midwifery, Powys/Fiona Ellis	Birthing centres operate on an 'on call' basis. Women receive continuity of carer. There is no obstetric unit in Powys. Birthing centres are located in community hospitals.	Consideration of birth centre/continuity of carer model as an option for delivery in Shropshire.

Telephone conversation with: Herefordshire and Worcestershire, Local Maternity System Herefordshire CCG North Wales Maternity Services Powys Maternity Services	3rd April 2018	N/A	Fiona Ellis, MLU Review Programme Manager Fay Baillie, Herefordshire and Worcestershire Local Maternity System Richard Watson, Herefordshire CCG Fiona Giroud, North Wales Maternity Services Julie Richards, Powys Maternity Services	North Wales – need to improve communications e.g. information-sharing and paperwork, particularly re: safeguarding for chaotic families. Worcestershire – access to scans is problematic as there are different forms and protocols; it's difficult for midwives to access case notes. Need to consider the impact on health visiting. Need to ensure that the appropriate impact assessments are completed to understand the likely impact and measure change. Need to gather feedback from women and staff on their experience and measure the impact.	

Appendix 3

Engagement with clinicians

Name/type of meeting	Date	Location	Attendees	Summary of feedback	How did feedback influence the proposals or the process?
Staff interviews in different locations (delivered independently by The ELC Programme) in July 2017	11th July 2017 12th July 2017 13th July 2017 14th July 2017 17th July 2017	Royal Shrewsbury Hospital, Bridgnorth Community Hospital Princess Royal Hospital, Telford Royal Shrewsbury Hospital, Ludlow Hospital Oswestry Cabin Lane Church Park Lane Centre and Princess Royal Hospital, Telford	85 in total (54 work in an urban setting and 31 in a rural MLU or are community-based.) 40 participants work mainly in MLUs and 14 mainly in the consultant-led unit. 57 midwives, 10 health care assistants, 1 health visitor, 5 GPs, 4 Obstetricians, 1 special care baby unit staff member, 1 children's hospice nurse, 1 breastfeeding volunteer, 3 housekeepers, 2 maternity services managers	Relationships with colleagues beyond the immediate team are fractured; many people feel unsupported by management (mainly staff in MLUs.) Poor relationship between MLU and CLU staff. Pressure to discharge to health visitors. Lack of shared patient information between midwives and health visitors. Antenatal and postnatal care is time-pressured; antenatal care needs to be improved. Unrealistic expectations and lack of resources. Little voice in or control over	Proposed staffing model has taken this feedback into account including: - more integrated working/co-location of services/professions - increased skill mix in staffing to enable midwives to focus on what they are especially trained to do - staffing deployed flexibly in line with demand - continuity of carer Actions in relation to staff wellbeing were passed to the Workforce Workstream of the Local Maternity System to

				working lives. Poor communication from managers to frontline staff. Hierarchical decision-making about changes. Staff need to be more involved. Lack of robust processes to support staff with their emotional wellbeing. Women's mental health before conception and parity of mental health are important. Importance of relationship-centred care and continuity of care. Challenges with GPs, particularly in relation to prescriptions and appointments (midwives) Lost touch with pregnant patients due to midwives leading maternity care (GPs) Challenging relationships with the triage service (particularly	address. Since then an increase in staff numbers has been agreed and additional staff are being recruited as a result. The service provider has increased engagement with maternity staff. The proposed service model also includes: - enhanced services available for women antenatally and postnatally - improved access to perinatal mental health services - peer support - a more social, less clinical model of care - consideration of access for women including those who rely on public transport. - Pathway changes so that the decision

				MLU midwives) Concern about staff and families without private transport, particularly high risk women having to travel to CLU when in labour Not enough time for home visits and concern that early warning signs are being missed Review processes are prescriptive with a lot of box-ticking; fear of repercussions and litigation. Parents often find it easier to speak to other parents who have had the same experience if they are struggling to cope. Concern that they (midwives) don't have enough time to spot if women are struggling or that they didn't have time to support if they did spot something. Investment in postnatal care improves mums' and babies' health and resilience in the long	about place of birth is made later on in pregnancy.

				term. Mums under social care supervision with safeguarding concerns on the postnatal ward take up a lot of staff time. Working in different and unfamiliar environments is difficult and risky (MLU staff in CLU.) The care that families get before and after the birth is vitally important. Postnatal care is vitally important including breastfeeding support, a safe space to reflect on birth, support for bonding between baby and family, meeting other ladies with shared experiences. The current clinical risk thresholds limit midwife-led births. Personalised care is a core care model principle.	

				We need to demedicalise pregnancy and birth and normalise low intervention births. Midwife-led care needs to have a broader focus, value ante- and postnatal care and not just be about the birth. Services need to be joined up across maternity and early years. Routine antenatal and postnatal care could be delivered in group clinics. Parents should make their choice about place of birth later than they do now.	
Written feedback from staff at Oswestry MLU	October 2017	Oswestry	Two midwives	Risk to reputation due to current closure and staff shortages. Unable to offer same quality and quantity of ante- and postnatal care. Increased administration leaves	Detailed population information has been considered as part of the options appraisal process including population growth predictions. Travel and access data has been considered during the

				less time to care for women. Growing local population and also from areas nearby. Travel and affordability issues – most women from lower/middle socio-economic groups. Postnatal inpatient care missed most by patients and staff. Community shifts require longer visits. The on-call system doesn't work. Our buildings are expensive. The hub model won't work; we should only provide community care if we don't offer an inpatient service.	options appraisal process as well as deprivation indicators. Cost of buildings considered during options appraisal process.
Telford and Wrekin CCG Planning Performance	28th November 2017	Telford	Two GP board members	Concern about high risk women who are smokers. Fear that the relocation of the new service is being driven by	The new model will address this issue. The new model will work better wherever services are

and Quality Committee				Future Fit and that the provider won't change the location of planned clinics without permission from clinicians.	as they would be delivered from the same place enabling patients to get to know the building and staff.
Email feedback	4th December 2017		Midwife	Current single telephone number for making appointments is not working - can be 100 phone messages in a morning - need to use email.	The need for good access and triage has been considered in developing the proposed staffing model.
Email feedback	16th December 2017		Clinician, RJAH	12 hour opening appears problematical (for births) - does model exist elsewhere?	Models operating in other areas were explored.
Telford and Wrekin CCG Board Meeting	9th January 2018	Telford	Telford and Wrekin GPs	Women with the highest risk after booking live in Telford & Wrekin. In fact, the ratio of women in Telford & Wrekin converting to high risk was a factor of 1:1 of all other births in other parts of the County. Therefore, there is a group of high risk women living in Telford & Wrekin who cannot be identified. How will these high risk women be cared for with a low risk Telford & Wrekin midwifery unit if the obstetric unit were to move under the	The new model would bring a broad range of services together to identify that risk early on in pregnancy.

				Future Fit proposals? Of the 48 high risk conversion reasons, 24 can be identified but the other 24 cannot. Is the model clinically financially sustainable? Could the provider deliver this model at tariff without overspending?	There are two elements (1) impact on the financial sustainability of the CCG and (2) impact on the local health economy; financial modelling has not yet been carried out as this is still being worked on. However, initial reviews have been carried out and all of the options proposed reduce the cost of the service that is being delivered which is more financially sustainable than the current model. The model would be delivered at a lower cost than the current service and that tariff is a national average. Overall the proposed model is a financially affordable plan; the current model is significantly over tariff.
West Midlands	28th March	N/A		Agreed for Stage 2 review to	N/A

Clinical Senate – Stage 1 Clinical Assurance Review	2018			take place.	
West Midlands Clinical Senate – Stage 2 Clinical Assurance Review	4th June 2018	N/A	Professor Simon Brake (Chair) Alison Talbot, Head of Midwifery and Associate Director of Nursing for Women, Children and Safeguarding Peter Thompson, Consultant Obstetrician, Fetal Medicine Peter Fahy, Director of Adult Services Soili Larkin, Public Health England York Galloway, Clinical Team Leader Andrea Batty, Clinical Manager/Maternity Advisor, WMAS	Ensure sufficient flexibility in MLU reconfiguration plans to implement independent review recommendations. Be aware that potential changes to the Maternity Pathway Payment System may have a direct impact on financial sustainability. Promote the benefits of the new model of intrapartum care. Describe the antenatal and postnatal pathway with risk stratification of patient groups. Develop a detailed workforce plan across the whole pathway working with HEE and the LMS. Develop a comprehensive	Actions have been addressed and are reflected in the pre-consultation business case.

			Babu Kumararatne, Consultant Neonatologist Richard Mupanemunda, Consultant Neonatal Medicine Louise Griew, West Midlands Maternity Services User Representative Andy Whallett, Health Education England Peter Pinfield, Patient Representative Gillian Stewart, Patient Representative	implementation plan reflecting national guidance to achieve a safe and equitable service. More assurance required with regard to workforce modelling, particularly for midwifery and acceptability to staff of rotation between sites. Have an open discussion with staff. Post consultation and pre-implementation take proposed staffing and implementation model back to Clinical Senate.	
Shropshire Locality Meetings	22nd August 2018 18th October 2018 25th October 2018	South Shrewsbury and Atcham North	GPs	Why can't midwives use more up-to-date technology? The midwifery antenatal service has taken away patient contact with GPs.	On-going work is taking place with the STP IT leads to try and improve this. We will consider how the maternity department feeds back to GPs.
Midwife-led Unity Review	24th October 2018		26 People working in or with midwifery led services	Feedback was not categorised by stakeholder group but	Proposed new staffing model incudes an increase in skill mix

Stakeholder Briefing			including: MLU managers from Shrewsbury and Bridgnorth Community/voluntary support staff from Telford and Bridgnorth Midwives from Shrewsbury and Telford Health visitors	overall feedback included: Lack of equity in banding across midwifery; need to recognise specialist roles Need a home birth team Need a drop-in breastfeeding clinic Need a robust staffing model so staff from MLUs aren't taken by CLU Need more detail around staffing including band 3 development Need training for all midwives on birth trauma and perinatal mental health Need to consider travel and transport for staff	and enables staff to be deployed in line with demand. Appropriate response for home births is included in the staffing model. Breastfeeding support will be available at the hubs on a drop in basis. Travel and transport for staff has been considered in developing the workforce model. Training for midwives has been passed to the workforce workstream of the Local Maternity System to address.
Presenting the evidence behind the review	6th November 2018	Telford and Wrekin CCG	Fiona Ellis, Andy Inglis, Adam Pringle	Welcomed insight to evidence and agreed that the evidence reflected what they see in relation to needs of the	Three localities in Telford, including South Telford included in the appraisal of

proposals to Telford and Wrekin GPs				population. Recognised the need for a hub in South Telford.	possible hub locations.
Expert midwife - Fay Baillie	Frequent contact from 2017 and ongoing	Frequent contact from 2017 and ongoing	Various, including telephone, email and face to face contact.	Expert advice and guidance in relation to good practice, pathways, service configuration and staffing models.	The advice and guidance given has been built into the service proposals.
Midwifery leaders in other areas e.g. Powys and Seacombe	To be updated	To be updated	To be updated	To be updated	To be updated
Options appraisal workshop 1	6th February 2019		23 clinical staff including: Midwives from Telford, Oswestry, Shrewsbury, Bridgnorth and Whitchurch MLU managers (Bridgnorth, Shrewsbury and Telford) Women's support assistants (Oswestry and Bridgnorth) Health visitors (Telford and	This workshop was about shortlisting the possible options and therefore there was limited feedback given. Feedback was also not recorded by different groups of people e.g. staff.	The views of the clinicians who attended this workshop were used as part of the options appraisal process.

			Ludlow) GP from Shropshire Obstetrician, neonatologist and neonatal nurse		
Options appraisal workshop 2	27th February 2019	Shrewsbury	Clinical staff in different roles including: CCG medical director Matron MLU manager Midwives (Whitchurch) Women's support assistant (Oswestry) Health visitors	Feedback was not recorded by specific groups at this workshop but general feedback from this workshop can be found below: • Consider a mix of MLUs with births and without births, not only 3 or 4 units with or without births. • If we have a mix of births and no births, this isn't equal. • They need to be at the same distance. • We need to look at demographics – depends where the hubs are located. • Need to look at transport availability.	Access impact assessment and Equality Impact assessment undertaken.

				• Need more midwives if there are births in more hubs. • Fragility and stability of service – more hubs. • Hubs with co-location of services are important for stability. • Need to change idea that care needs to be offered in a building. • Midwives are concerned how they will do it all. • Have you looked at other places for best practice e.g. Angus in Scotland? • Comfortable with scores following sensitivity analysis. • Ellesmere is covered by Oswestry but this is included in the North Shropshire figures. The data is skewed. • Roads from Ellesmere	

				are difficult to Whitchurch. • Need to consider the business of the hubs – have you looked at workload now? • In Oswestry, I saw 10 patients before I left for this meeting. In Whitchurch, they see 7 patients a day. • I have done a similar piece of work looking at fertility rates in Shropshire and the results would be the same. • Issue of transport in Shropshire. • Lakeside South and Hadley Castle aren't far from PRH so might not need births in hubs there. • A higher percentage of women in Telford would go to the	

				consultant-led unit due to their high level of risk so we wouldn't need births at Lakeside/Hadley Castle. • We see a lot of Powys ladies in Oswestry – it's a long way for them to travel to Whitchurch. • These women are giving birth in Wrexham. • Need to consider where the best place is for the freestanding MLU – not in a hospital. Would need a bigger unit if were including births. • It feels like we're saying that all the MLUs would be based in the middle of the county. • Equality is about meeting need. Lakeside South has the most deprived population and it has difficulties in travelling.	

				• Everybody identifies with where they live – "place." We need to think more about the geography and people who might be less willing or able to seek help. • There's more need in the middle of the county. • Shropshire is very rural – we are ignoring rural areas. • It has taken me 50 minutes to get to Shrewsbury from Ludlow today. • Need to be careful how we describe this to the public. It's important to explain the community approach and that appointments will be available in local places if there's not going to be a hub in Ludlow.	

				• There's only a small difference in the data results for South and North Shropshire. • At the RCM conference in 2017, Shropshire was described as a wonderful case. This is about finance. • The model looks lovely but there are not enough women giving birth in the MLUs. • People need to change their mindset about where they receive care. • If you can't provide the service now, how can you staff 4 hubs? • It's easier to look after a lot of people in one place if you are short-staffed rather than travelling around the county. • Midwives are currently	

				duplicating work, not using HSAs effectively and not working in a multi-disciplinary way? • Midwives are leaving small units because they're not able to deliver babies. • We can't take everything away in rural areas.	
Stakeholder workshop	29th April 2019	Telford	7 clinical staff including: 2 MLU managers (Shrewsbury and Bridgnorth) 2 Matrons 1 health visitor (Hadley Castle/North Hadley) 1 women's support assistant (Oswestry) 1 midwife sonographer	Location of care if there's no hub Need to check if Ellesmere women who are looked after in Oswestry have been included in North Shropshire figures It's taking a long time. We need to make the changes ASAP. Who would cover the	It could be different locations, a GP practice, community centre or a health visitor hub, for example. We will look into this. There are certain processes we need to follow but we recognise the need and are working as quickly as possible. A community team including

				Bridgnorth area? Integrated care records Have the consultation events at different times of the day Engage with women in the outpatient departments at RSH and PRH and leisure centres/gyms	home births would be deployed county-wide. This is a key piece of work for the LMS. We will ensure we have a broad mix of times for our events. We will include these in our consultation plan.

Appendix 4

Engagement with non-clinical staff

Name/type of meeting	Date	Location	Attendees (type and number)	Summary of feedback	How did feedback influence the proposals or the process?
Shropshire CCG Executive team meeting	6th November 2017	Shrewsbury	To be updated	To be updated	To be updated
Shropshire CCG Clinical Commissioning Committee meeting	15th November 2017	Shrewsbury	13 people including CCG Lay Members, GPs and CCG Directors	It was noted that the proposed model includes pre-pregnancy care, healthy lifestyle and mental health support in a consistent manner in line with Better Births guidance. It is proposed that the choice of options for care is retained but the number of free-standing MLUs is reduced along with the number of long inpatient stays. Pathways with Out of County Hospitals will also be improved. It was suggested that the transport section of the proposal is revised as longer-term discussions will need to be held around public transport, parking etc. It was also requested that the location of the 2 proposed MLUs is made clearer in the document.	Detailed access and impact assessment undertaken.

Telford and Wrekin CCG Planning Performance and Quality Committee	28th November 2017	Telford	Accountable Officer Chief Finance Officer Executive leads for commissioning, governance and engagement and nursing and quality Two GP board members	Why will hubs be open 12 hours and not 24 hours? Concern about high risk women who are smokers. Fear that the relocation of the new service is being driven by Future Fit and that the provider won't change the location of planned clinics without permission from clinicians. What about workforce issues? Would the new service be part of a block contract or a standalone specification?	A 24 hour service isn't sustainable. The new model will address this issue. The new model will work better wherever services are as they would be delivered from the same place enabling patients to get to know the building and staff. The hubs would be appropriately staffed to meet demand. It would be a standalone specification.
Shropshire CCG Board meeting	13th December 2017	Shrewsbury	CCG chair Deputy chair/clinical director, women's and children's Accountable	Issue around expectant mothers giving birth before arrival. Would there be sufficient midwife cover for home births? How is access being taken into account?	The rate of birth before arrival is in line with the national average. There are no changes proposed to the current community midwife cover. It would still be 24/7 with a midwife a maximum of one hour away. Safety is the priority and although some mothers might have to travel slightly

			Officer Chief Finance Officer Two GP board members Three locality chairs/GPs Three CCG directors Three lay members		further to give birth, there would be additional ante- and postnatal services locally.
				What consideration has been given to patients in north-east Shropshire?	The preferred option is for a minimum of 5 hubs as they need to be reliable and sustainable.
				Have discussions taken place with the Director of Children's Services?	Discussions are taking place about potentially delivering early years' services from the hub.
				Welcome use of maternity support workers to assist with postnatal care. How quickly can they be recruited and what training do they need?	Maternity support workers are already embedded in secondary care and any posts advertised are recruited to quickly. There would be on the job training through an NVQ.
				Have the views of service users who aren't normally forthcoming been considered?	Interviews were conducted at ante- and postnatal clinics where service users would be.
				Anxiety that not all public and patient views have been considered.	The views of everyone who has come forward during phases 2 and 3 of the review have been considered. The trends and themes from the engagement work have been used to develop the model.
				What are the plans for further consultation on	The model is not fully developed. This will

				the proposed model? Has any information been gathered in relation to outcomes in the options appraisal? Has there been any feedback to the Trust about the low staff morale identified in the review? Is there any research showing that midwives need to attend a minimum number of births to ensure their skills are maintained? <u>Public and patient views</u> Hubs should be in the most deprived areas. Concern that local births in Ludlow, Oswestry and Bridgnorth are being removed. Safety of home births for first-time mums. Awareness of alternative models e.g. Powys, with small number of births. Issues of unreliable maternity service delivery	be developed as part of the consultation phase. Historically the focus has been on demand and activity but in future the proposed model was designed with patient outcomes as the key driver. The outcome of the review has been shared with SaTH's director of nursing, head of midwifery and head of workforce. Research by Professor Denis Walsh shows that an average of 250 births a year in a freestanding MLU tends to be the viability threshold for standalone MLUs.

				and staffing problems – SaTH had reduced number of WTE midwives. Four recent "delivery before arrival" births in Ludlow. Have the two letters from national maternity leaders raising concerns about the proposed model been shared with governing body members? Have the proposals been rural-proofed? There's a feeling that women in rural areas aren't being heard. Has the potential population increase been considered? Concern about discrepancies in financial figures. Significant areas of deprivation in Telford and Wrekin need to be considered.	
Telford and Wrekin CCG Board Meeting	9th January 2018	Telford	CCG Chair CCG Chief Officer Three executive	Women with the highest risk after booking live in Telford & Wrekin. In fact, the ratio of women in Telford & Wrekin converting to high risk was a factor of 1:1 of all other births in other parts of the County. Therefore, there is a group of high risk women living in Telford & Wrekin who cannot be identified. How will these high risk	The new model would bring a broad range of services together to identify that risk early on in pregnancy.

			leads Two lay members Two secondary care clinicians Four GPs/board members	women be cared for with a low risk Telford & Wrekin midwifery unit if the obstetric unit were to move under the Future Fit proposals? Of the 48 high risk conversion reasons, 24 can be identified but the other 24 cannot. From a Telford & Wrekin perspective a lot of rural access issues have been identified in the report. Would the Telford & Wrekin Unit be on the PRH site? If so, it is not recognising some of the issues that the families face as PRH is too far from where they live and what access would there be in terms of public transport? We are building inequity in terms of access to the maternity hubs if there is only going to be one in Telford & Wrekin at PRH. The report did not give a sense of how many hubs are affordable as there did not appear to be sufficient information on this point. Is the model clinically financially sustainable?	The key aim is to ensure sustainable services. It has not been decided where the hubs should be located although it does make sense for MLUs to act as hubs also. A discussion regarding location and access of the hubs will be carried out later on in the review. There are two elements (1) impact on the financial sustainability of the CCG and (2) impact on the local health economy; financial modelling has not yet been carried out as this is still being worked on. However, initial reviews have been carried out and all of the options proposed reduce

					the cost of the service that is being delivered which is more financially sustainable than the current model.
				Could the provider deliver this model at tariff without overspending?	The model would be delivered at a lower cost than the current service and that tariff is a national average. Overall the proposed model is a financially affordable plan; the current model is significantly over tariff. There is no financial impact on the CCG but on the sustainability of the local health economy.
				The hubs should be located where they are most needed. Wouldn't expect to have the hub locations specified now but these should be looked at following consultation.	
				The document isn't clear to the public. More work needs to be carried out in relation to costings.	This will be put in place and shared with the Board for approval.
				Is a synopsis of the public consultation available?	Each hub will operate for 12 hours with an additional service 24/7 for hospital births and home births.
				<u>Feedback from members of the public</u> SaTH has shown no commitment to community	

				midwife services and a balance between the available times of midwives is needed to cover the hubs. Telford and Wrekin has communities who are not able to travel and we need to be careful that these people aren't prejudiced. We need to look at where most births are before there's a decision about the locations. No more than two hubs are needed, one in the south of Shropshire and one in the north. They need to be nearest to working class communities and the poorest women who need them most.	

Appendix 5

Engagement with politicians/MPs

Name/type of meeting	Date	Location	Attendees	Summary of feedback	How did feedback influence the proposals or the process?
MP meeting	9th December 2016	Shirehall, Shrewsbury	Daniel Kawczynski Owen Paterson Philip Dunne	All agreed with rationale of review, findings to date, proposed model. No one raised objections.	N/A
MP meeting	6th April 2017	Ludlow	Philip Dunne	Discussion around data, underutilisation of current service model, case for change and structure of engagement plans	N/A
MP meeting	19th January 2018	Shirehall, Shrewsbury	Daniel Kawczynski Owen Paterson Philip Dunne	All agreed with rationale of review, findings to date, proposed model. No one raised objections.	N/A
Oswestry Health Group	26th January 2018	Oswestry	Owen Paterson MP (Chair) Fiona Ellis, Programme	"Many challenging questions were then directed around statistics and the need for certainty going forward which is currently affecting family decisions in	Further in-depth analysis was undertaken in order to inform the final proposal.

			Manager David Preston, Oswestry Town Clerk and three town councillors	terms of birth options."	
Oswestry Health Group	8th March 2019	Oswestry	Owen Paterson MP (Chair) Fiona Ellis, Programme Manager David Preston, Oswestry Town Clerk and three town councillors	"The removal of maternity in terms of clinics of GPs was discussed. Concern was also voiced at the number of surrounding villages that have large populations that require access to future hubs."	Access impact assessment has been undertaken. Communities across the county will continue to receive planned antenatal and postnatal care close to home including at GP practices, children's centres and other community venues as well as at home.

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Appendix 6

Engagement with Councils

Name/type of meeting	Date	Location	Attendees (type and number)	Summary of feedback	How did feedback influence the proposals or the process?
Shropshire Council Health and Wellbeing Board	16th November 2017	Shrewsbury	6 members including: PFH Health and Adult Social Care Director of Public Health Director of Children's services Clinical Chair, Shropshire CCG Chief Executive, Healthwatch Shropshire	Members commented generally that workshops had been well attended and that the review and engagement undertaken thus far had been excellent. Congratulations were extended for a brilliant piece of work.	N/A
Telford and Wrekin CCG Planning Performance and Quality Committee	28th November 2017	Telford	Consultant in Public Health, Telford and Wrekin Council	No specific feedback recorded but general feedback from the meeting can be found in section 2.4.	See section 2.4 above.
Joint Health Overview and Scrutiny Committee	5th December 2017		17 attendees including: Shropshire Councillors: Karen Calder (Co-Chair), Madge Shineton Telford and Wrekin Councillors:	CCG Boards need to consider where the gaps are e.g. North Shropshire. A strong and clear vision is needed.	Further in-depth data analysis was undertaken as part of the options appraisal process.

			Stephen Burrell Shropshire Co-optees: David Beechey (Healthwatch), Mandy Thorn (Chair, Shropshire Business Board; MD of Marches Care Ltd; vice-chair of Shropshire Partners in Care and trustee of Healthwatch) Telford and Wrekin Co-optees: Carolyn Henniker (Healthwatch), Hilary Knight (Deputy chief executive, Age UK Shropshire Telford and Wrekin) Director of Public Health, Shropshire Council	Impact of the proposals on resources and whether they would prevent outreach services closing when staff are off sick. It's obvious that services are under extreme pressure and are only standing due to the goodwill and professionalism of staff. The time for a review is right.	
Shropshire CCG Board Meeting	13th December 2017	Shrewsbury	Director of Public Health, Shropshire Council	What consideration has been given to patients in north-east Shropshire? Have discussions taken place with the Director of Children's Services?	The preferred option is for a minimum of 5 hubs as they need to be reliable and sustainable. Discussions are taking place about potentially delivering early years' services from the hub.
Telford and Wrekin CCG	9th January	Telford	Assistant Director of Health and	From a Telford & Wrekin perspective a lot of rural	The key aim is to ensure sustainable services. It has

Board Meeting	2018		Wellbeing, Telford and Wrekin Council and an observer	access issues have been identified in the report. Would the Telford & Wrekin Unit be on the PRH site? If so, it is not recognising some of the issues that the families face as PRH is too far from where they live and what access would there be in terms of public transport? We are building inequity in terms of access to the maternity hubs if there is only going to be one in Telford & Wrekin at PRH. The report did not give a sense of how many hubs are affordable as there did not appear to be sufficient information on this point. The document isn't clear to the public. More work needs to be carried out in relation to costings.	not been decided where the hubs should be located. A discussion regarding location and access of the hubs will be carried out later on in the review. The decision the Board is asked to make is whether to go out to consultation and decisions regarding access should be discussed during the consultation. There is no financial impact on the CCG but on the sustainability of the local health economy.
Email	5th February 2018	N/A	David Preston, Town Clerk, Oswestry Town Council	Strong view the midwife-led services should be retained	View acknowledged. Further in-depth analysis to inform hub locations was

				in Oswestry.	undertaken as part of the options appraisal process.
Telford and Wrekin Council Health and Wellbeing Board	7th March 2018		12 members including: Cabinet Member – Communities, Health & Wellbeing, TWC Chair, Telford & Wrekin CCG W Condlyffe, Chief Officer Group Representative Sustainability & Transformation Plan Representative Assistant Director, Adult Social Care Director of Children's & Adult Services Director of Public Health Telford & Wrekin Healthwatch Cabinet Member – Children's & Adult's Early Help & Support	The Cabinet Member for Children and Adult's Early Help & Support reinforced the need for social economic differences across the county be addressed appropriately.	Socio-economic indicators were considered as part of the options appraisal process.
Joint Health Overview and Scrutiny	22nd March	Shrewsbury	Shropshire Councillors: Karen	Would there be at least 5 hubs as mentioned in the	Five hubs would be

Committee	2018		Calder (Co-Chair), Madge Shineton Telford and Wrekin Councillors: Andy Burford, Stephen Burrell Shropshire Co-optees: David Beechey (Healthwatch), Ian Hulme (Shropshire Patients Group) Telford and Wrekin Co-optees: Hilary Knight (Deputy chief executive, Age UK Shropshire Telford and Wrekin), Dag Saunders (Chair, Healthwatch) 6 Members of Shropshire Health and Adult Social Care Overview and Scrutiny Committee Public Health, Shropshire Council	presentation? Would there be just one hub in Telford with a growing population and areas of deprivation? Need to consider public transport challenges to PRH. If services are being levelled up, why won't there be a hub in North Shropshire? What will happen to midwives currently based in Whitchurch? Are the proposals in line with Better Births? How is the local maternity system working together to deliver transformation and	sustainable. The proposal is for a hub in Telford with outreach to meet local needs. Areas of deprivation have been considered and a hub and spoke model would strengthen antenatal care. The new model would change so that each hub would provide the same service and outreach would be designed around the needs of communities. Their base would change to Oswestry but the service provision in the north of the county wouldn't change. Yes, they will increase the number of midwife-led births. CCGs are legally responsible for transformation. The LMS has a programme board

				who is driving this?	including the local authorities, the CCGs, service providers, service users, WMAS, neonatal and mental health service representatives.
				Why is staff morale so low? Have staff been fully engaged?	Staff have been under pressure as there has been a need to distribute staff differently and suspension of MLU services had often been ad hoc. Midwives wanted clarity and they are fully supportive of the proposals.
				What will be the impact on health visitors?	This is a matter for the local authorities.
				What does 24/7 community care mean?	A phone call, video link or face-to-face contact depending on patient needs.
				How's recruitment progressing?	Recruitment to band 6 and 7 posts and newly qualified midwives has been successful.
				Why is there trend to give birth in the consultant-led unit? Is this due to the	This is a national trend but

				uncertainty of the MLUs?	uncertainty about the MLUs and high profile sad cases have impacted on patient choice.
				How has West Midlands Ambulance Service been involved?	WMAS now has a midwifery lead who is well engaged in the maternity system.
				Will there be a clear pathway between Shropshire services and out-of-county services?	Work is underway to build better links with neighbouring areas and to improve cross-border pathways. We are also looking at digital technology to see how patient records can be shared more easily.
				Is there enough capacity to facilitate home births?	A lot of work has been done about capacity and the proposal would deliver the service needed.
				How does the NHS assurance process work? When would the Clinical Senate be involved?	The Clinical Senate is part of the NHS assurance process. The Clinical Senate checks if a proposal is safe and offers the appropriate care.

				Where does the JHOSC fit in the consultation plan?	We will keep Chairs updated on progress.
Shropshire Council Health and Wellbeing Board	24th May 2018	Shrewsbury	8 members including: Director of Public Health Clinical Chair, Shropshire CCG Director of Children's Services VCSA Chairman, Shropshire Partners in Care Shropshire Community Health Trust PFH Health and Adult Social Care	Report presented. No feedback given.	N/A
Joint Health Overview and Scrutiny Committee	3rd December 2018	Shrewsbury	Shropshire Councillors: Karen Calder (Co-Chair), Heather Kidd, Madge Shineton Telford and Wrekin Councillors: Andy Burford, Stephen Burrell, Rob Sloan Shropshire Co-optees: David	SATH has recently agreed to extend closure of MLUs for a further year – how will that impact on proposals?	Closure of the MLUs on safety grounds did not impact directly on the review which was a distinct process. However, the inability to staff the current model had been a driver for the review. The MLUs did not currently have births and postnatal

			Beechey, Ian Hulme Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight, Dag Saunders Rod Thomson, Director of Public Health, Shropshire Council	What will the public consultation look like? Was it envisaged that there would be a preferred option set out in the consultation? The number of hubs was likely to be a key issue of debate with rural Shropshire and high levels of need in some Telford areas with critical issues around maternity.	stays but were open to provide other services. Advice on the consultation was being sought from the STP Communications and Engagement Team and the intention was to conduct as exhaustive a consultation as possible. The consultation plan would be presented to the Joint HOSC for its input. A preferred option would be identified but all clinically and financially viable options would be included. This is yet to be confirmed. It was hoped that discussion around hub locations would not be divisive. The review area was all part of the same system within the STP footprint. A huge amount of information had been collected for over 10 years

				Was data likely to be skewed on use of Consultant Led Units (CLU) and Midwife Led Units (MLU) as many had not booked in to a MLU due to availability being unreliable? The list of services to be offered from hubs includes areas covered by Public Health funding, for example, obesity and smoking cessation. What will be consulted on if Public Health funding no longer covers these areas? Could there be long term risks to health safety and welfare if the proposed cuts to the Public Health budget take place?	on trends for birth preferences, before temporary closures had become necessary and also on the level of need in Telford and Wrekin and Shropshire. All recommendations would be evidence based. It was also pointed out that the current configuration was inequitable. Public health funding is a key concern for CCGs in keeping women and babies healthy and well, particularly in relation to smoking and obesity. It is not clear yet how this would be resourced but there is a joint programme and care would be taken to ensure there is no duplication. All of these issues would be considered together. The reporting date for the

				To what extent would Independent investigations into Maternity Services influence thinking? Clarity of the role of GPs would be required.	Ockenden review has been moved back several times already as the investigation has expanded. It had been decided not to delay the CCGs' MLU review to await an outcome but if any changes were subsequently needed then they would be addressed at that time. Patients have told us that they want GPs to be more involved in maternity care and they have a key role in co-ordinating health and liaising with services on behalf of mother and baby patients. In recent years there had been a shift in maternity care being provided exclusively by midwives and this had led to GPs not being as confident in delivering these services. Although it was not envisaged that GPs would be located in hubs, better

				Would the public consultation fall within the summer holiday period. Were there any lessons to learn from the timing of the Future Fit consultation?	communication was envisaged. A key message had been that there was now too much emphasis on the birth plan and not enough on becoming a family. If the consultation falls within the summer holiday period, this will be taken account of in terms of the length of the consultation period.
Options Appraisal Workshop 1	6th February 2019	Telford	Joint HOSC Chair and one other JHOSC representative (observers) 2 representatives from Telford and Wrekin Council and 1 from Shropshire Council Public Health teams	This workshop was about shortlisting the possible options and therefore there was limited feedback given. Feedback was also not recorded by different groups of people.	The views of the JHOSC and Public Health staff who attended were taken into account as part of the options appraisal process.
Options Appraisal Workshop 2	27th February 2019	Shrewsbury	One JHOSC representative 1 representative from each of the Councils' Public Health teams.	A higher percentage of Telford women would go to the consultant-led unit due to the high level of risk so we wouldn't need births in Lakeside South or Hadley	Options with and without births have been evaluated. The needs of the local population have been evaluated in both the options appraisal process and

				Castle. (Public Health, Telford and Wrekin.) Equity is about meeting need. Lakeside South has the most deprived population. Most feedback was not recorded by different groups of people. However detailed feedback from the group as a whole can be found in section 2.3 above. Where known, specific feedback has been highlighted above.	through the equality impact assessment. The views of the JHOSC and Public Health staff who attended were taken into account as part of the options appraisal process.
Stakeholder Workshop – update on options appraisal	29th April 2019	Telford	One JHOSC chair 1 representative from Public Health at Telford and Wrekin Council.	Have you considered Welsh women? Most feedback was not recorded by different groups of people. However detailed feedback from the group as a whole can be found in section 2.3 above. Where	Welsh women wouldn't be impacted on by these proposals as they only come to Shropshire for consultant-led maternity care. The views of the JHOSC and Public Health staff who attended were taken into account as part of the options appraisal process.

				known, specific feedback has been highlighted above.	

Appendix 7

Engagement with Healthwatch

Name/type of meeting	Date	Location	Attendees (type and number)	Summary of feedback	How did feedback influence the proposals or the process?
Joint Health Overview and Scrutiny Committee	5th December 2017	Shrewsbury	David Beechey (Healthwatch Shropshire) Carolyn Henniker (Healthwatch Telford and Wrekin)	See section 2.6 above	See section 2.6 above
Letter from Healthwatch Shropshire	6th December 2017	N/A	N/A	We absolutely welcome the approach taken to the review with respect to the engagement activity and review of current intelligence. We also appreciate your response to our earlier comments about the public documentation and the development of the 'You Said, We Did' sections to give more clarity to the decision making.	The service model takes account of feedback gathered in all phases of the service review. Phase 1 of the review analysed existing information, including activity data. Through Phase 2 new qualitative information was gathered through in-depth interviews with women and staff. Phase 3 brought commissioners, women, staff and other community members together to think about what

				However, we are concerned that the response is lacking with regards to the reduction of inpatient postnatal care. We believe that you need to specifically address why postnatal beds will not be provided across the county. We are concerned that under the new model currently proposed there will not be enough postnatal beds at the CLU for short term stays. We would like to propose that there are post-natal beds at the MLUs in Shrewsbury and Telford. We would like to register our concerns now about the	a future model of care may include. The number of inpatient postnatal beds included in the proposed new model has been calculated using a nationally well regarded bed-modelling tool (Northwick Park Model). The proposed new model includes provision for women to stay where they have given birth for a period of time before they go home. This period of time has not been defined, as this will be different depending on the needs and choices of each woman. If a woman needs a longer postnatal stay than the MLUs can accommodate, she will be able to access inpatient postnatal care at Princess Royal Hospital. In undertaking the review, we have employed an expert

				safety of the home birth service and the availability of midwives to cover all areas of the county in a timely manner. We are also concerned about the lack of parity of services for the North East of the county. The hubs stated in the model will cover the previous MLU sites but we would welcome more capacity in provision for the women in Market Drayton, Whitchurch and surrounding areas.	midwife with decades of experience in midwifery, including at Director of Nursing and Head of Midwifery level to ensure that the proposed model is safe and sustainable. The proposed model has been designed to include a safe and sustainable home birthing service 24/7 across the county. Included in the options appraisal for the proposed service model, was an option for an additional maternity hub in the Market Drayton/Whitchurch area. Through working with the expert midwife in relation to the safety and sustainability of the proposed service model, it was identified that the option of an additional hub in the Market Drayton/Whitchurch area would negatively impact

					upon the sustainability of the service and therefore has not been put forward as the preferred option.
Telford and Wrekin Council Health and Wellbeing Board	7th March 2018	Telford	Telford & Wrekin Healthwatch	No feedback recorded.	N/A
Joint Health Overview and Scrutiny Committee	22nd March 2018	Shrewsbury	David Beechey (Healthwatch Shropshire) Dag Saunders (Chair, Healthwatch Telford and Wrekin)	See section 2.6 above	See section 2.6 above
Options Appraisal Workshop 1	6th February 2019	Telford	Chief Officer, Healthwatch Shropshire General Manager/Chief Officer and Engagement Manager, Healthwatch Telford and Wrekin	This workshop was about shortlisting the possible options and therefore there was limited feedback given. Feedback was also not recorded by different groups of people.	The views of the Healthwatch staff who attended were taken into account as part of the options appraisal process.
Options Appraisal Workshop 2	27th February 2019	Shrewsbury	Chief Officer, Healthwatch Shropshire General Manager/Chief Officer and Engagement Manager, Healthwatch Telford and Wrekin	We need to be careful how we explain this to the public. It's important to explain the community approach and that local appointments will	This will be taken into account in the content of the consultation materials and the consultation. communications.

				be available. People need to change their mindset about where they receive care. Suggest the hubs are called "community hubs" Most feedback was not recorded by different groups of people. Detailed feedback from the group as a whole can be found in section 2.3 above.	The views of the Healthwatch staff who attended were taken into account as part of the options appraisal process.
Stakeholder Workshop – update on options appraisal	29th April 2019	Telford	Chair, Healthwatch Shropshire	How were the localities derived? Link of maternity services to other children's services We need to be clear about the model and what it will look like	These are the same localities that were used for Future Fit. We are already talking to the Councils about family and children's hubs and we will link up wherever we can. We are working to develop a clear model and will ensure that this is described in a patient-friendly way in our consultation materials.

Appendix 8

Engagement with voluntary and community organisations

Name/type of meeting	Date	Location	Attendees (type and number)	Summary of feedback	How did feedback influence the proposals or the process?
Joint Health Overview and Scrutiny Committee	5th December 2017	Shrewsbury	Mandy Thorn (Chair, Shropshire Business Board; MD of Marches Care Ltd; vice-chair of Shropshire Partners in Care) Hilary Knight (Deputy chief executive, Age UK Shropshire Telford and Wrekin)	See section 2.6 above	See section 2.6 above
Email from Birthrights to Dr Simon Freeman, Accountable Officer, Shropshire CCG	7th December 2017	N/A	N/A	Closure of MLUs raises safety issues and creates anxiety for women who have to travel further in labour, away from their family and unfamiliar healthcare professionals. Local community hubs that do not offer birth and immediate postpartum facilities are not a viable alternative whatever	The principles of the proposed model include the retention of the full range of birth settings for women in Shropshire, in line with the recommendations of 'Better Births'. This includes births continuing to be available in the following settings: - Consultant Led Unit

				else they offer. Removal of patient choice – concern about women having a home birth waiting up to two hours for a midwife and that this will discourage first time mums and women who have had a short labour before from having a home birth. How will you improve the on call system to change this? Why have births in the FMU and AMU fallen despite the closure of 3 rural MLUs? This suggests they are not seen as realistic alternatives or a weak commitment to increasing births in midwife-led settings. How does this fit with Better Births and the goals of the Maternity Transformation Programme to ensure women are offered a full range of birth options including giving	- Alongside Midwife Led Unit (on the same site as the consultant led unit) - Freestanding Midwife Led Unit (not on the same site as the consultant led unit) - Home Birth available 24/7 This proposed new service model also includes the introduction of maternity hubs, in line with the requirements of 'Better Births'. The proposed five maternity hubs across the county would include antenatal and postnatal care which would be far more comprehensive than what is currently offered, meaning women will make fewer journeys through their pregnancy than they do

				birth in local communities?	under the current system. It would also have an equal offer at all hubs – something that is not the case currently. The hubs would include a broad range of services for up to 12 hours a day. This would include midwifery care, mental health and emotional wellbeing services, obstetric clinics, scanning and day assessment, including CTG monitoring, as well as other services including healthy lifestyle services, support from women's support assistants, and peer support. You will note that paragraph 4.30 of Better Births states that '….in some community hubs there may be birthing facilities'. Indeed, in our service model we included a proposal for the maternity hubs in Shrewsbury and Telford to be on the same

					site as the MLUs, which will offer births 24/7. An expert midwife from a different area reviewed the on-call arrangements. Following her findings, a new on call system has been put in place considering staff travelling times balanced against where they live and the rotation of midwives across the whole midwifery service. This new model meets the needs of the staff in terms of geographical distance to travel when on-call so they can get to a woman within an hour. The reduction in births in Midwifery Led Units is in line with the increase in need of pregnant women in Shropshire, Telford and Wrekin. The percentage of women giving birth in our Consultant Led Unit is in line

					with the findings of 'Better Births' where 87% of babies are now born in Consultant Units nationally, compared to 85% of Shropshire babies. The evidence shows there is no increase in the number of women giving birth before a midwife arrives due to the closure of rural MLUs. The evidence also shows that our rate of births without an appropriate medical professional present are in line with the national average. Our proposed new model would increase the proportion of women giving birth in midwifery led settings by: - Over time, increasing 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 women 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 staff who work there - Enabling women to make a decision about their preferred place of birth later in pregnancy - Moving the alongside MLU closer to the consultant led unit in order for a different level of risk to be safely managed. The proposed model is safe. The proposed model matches midwife presence to activity and demand so that

					every woman gets 1:1 care from a midwife during labour.
Christmas Card from AIMS	21st December 2017	N/A	Debbie Chippington Derrick, Chair of AIMS Trustee, on behalf of AIMs	Harm is being done to women by denying them FMU care e.g. unnecessary caesarean, forceps, ventouse, serious perineal trauma, blood transfusions, admission to a higher level of care, general anaesthetic, episiotomy. Dreadful for women and families but also puts unnecessary strain on other services including the ability of the obstetric unit to care safely for women who need to be there. Support letters sent by Birthrights and MuNet.	The proposed model includes midwifery-led care in both free-standing and alongside midwife-led units in Shropshire, Telford and Wrekin.
Telford and Wrekin Council Health and Wellbeing Board	7th March 2018	Telford	W Condlyffe, Chief Officer Group Representative	Report presented. No feedback given.	N/A

Joint Health Overview and Scrutiny Committee	22nd March 2018	Shrewsbury	Hilary Knight (Deputy chief executive, Age UK Shropshire Telford and Wrekin)	See section 2.6 above	See section 2.6 above
Shropshire Council Health and Wellbeing Board	24th May 2018	Shrewsbury	VCSA Chairman, Shropshire Partners in Care	Report presented. No feedback given.	N/A

Transforming Midwifery Care
in Shropshire, Telford & Wrekin

Appendix 9

Engagement with patients and members of the public

Name/type of meeting	Date	Location	Attendees	Summary of feedback	How did feedback influence the proposals or the process?
Patient interviews in different locations (delivered independently by The ELC Programme)	July - September 2017	5 MLUs Consultant-led unit wards Antenatal and postnatal clinics Mother and baby groups	132 women and mothers who are pregnant or have a baby up to the age of two years, and partners of these women 108 – rural areas 24 – urban areas	<u>Women in urban areas</u> If women require help and support or investigations early in pregnancy, they can feel patronised and some GPs and consultants are unhelpful. Experiences of planned antenatal care are positive. Postnatal care needs to be improved, with chaotic wards, a clinical experience and women feeling	The views gathered through the patient interviews have been integral in informing the service model. The proposed new model includes enhanced services during the antenatal and postnatal periods. Peer support has been included in the new service model. The proposed new staffing model will deliver continuity of

				isolated and "pushed out" of the ward quickly. <u>Women in rural areas</u> Same feedback as above plus: Anxiety about travelling a distance to hospital in labour Challenge of being told to go home when they were in labour due to long journey Positive experience of postnatal care in an MLU <u>General</u> Mum friends are important; it's easier to make mum friends on an MLU ward than on a CLU ward.	carer. There will be an increased skills mix in the proposed new staffing model, including more women's support assistants. The proposed new model encourages professionals in different services to work more closely together. Planned antenatal and postnatal care will continue to be available in communities across the county in a range of settings including GP practices, children's centres, community centres

				Being cared for by a small team of midwives is important; continuity is valued. High quality postnatal care and support from women's care assistants is valued e.g. help with breast feeding and bonding between mum and baby. Mixed relationships with GPs; struggle to get appointments and some disinterested. Mixed experiences of consultants; women felt like they had no choice in the pace of birth. Antenatal and postnatal care close to home and midwives	and at home.

				nearby is important. Having someone local to call and a place to go at anytime when they go into labour is valued. Emotional resilience after the birth is influenced by having time and space to recover on an MLU ward, meeting mum friends, open access for visitors and support from midwives. Better access to ultrasound would improve the experience. Need improved communication at the CLU and more time to care.	

				Clinical protocols to measure baby movements and the bump need to improve.	
Shropshire CCG board meeting	13th December 2017	Shrewsbury	Shropshire Patient Group representative Members of the public attending board meeting	Issue around expectant mothers giving birth before arrival. Would there be sufficient midwife cover for home births? Hubs should be in the most deprived areas. Concern that local births in Ludlow, Oswestry and Bridgnorth are being removed.	The rate of birth before arrival is in line with the national average. There are no changes proposed to the current community midwife cover. It would still be 24/7 with a midwife a maximum of one hour away. In determining the location of the hubs, a number of factors have been considered, including deprivation.

				Safety of home births for first-time mums. Awareness of alternative models e.g. Powys, with small number of births. Issues of unreliable maternity service delivery and staffing problems – SaTH had reduced number of WTE midwives. Four recent "delivery before arrival" births in Ludlow. Have the two letters from national maternity leaders raising concerns about the proposed model been shared with governing body members? Have the proposals	Other models of care have been explored and have informed the proposed new model of care.

				been rural-proofed? There's a feeling that women in rural areas aren't being heard. Has the potential population increase been considered? Concern about discrepancies in financial figures. Significant areas of deprivation in Telford and Wrekin need to be considered.	
Correspondence received by letter and email from a number of groups and individuals (16)	August 2017 – June 2018	N/A	Individual members of the public/patients, campaign groups	Proposed model contradicts what was overwhelmingly supported in previous meetings. Axing of local postnatal care and birthing facilities in Oswestry is unacceptable and not	Views have informed the proposed service model, including through the more in-depth analysis taking consideration of population, deprivation and access factors. The elements of MLU

				in line with feedback from service users. Closure of Ludlow MLU endangers lives of mothers and babies, will drive young people away from rural communities and is the result of manipulation as staff have been moved to RSH and PRH. Concern about closure of Ludlow and other maternity units. Closure of birthing unit at Ludlow is a cost-saving measure and risky for mothers and children having to travel to the consultant unit. What plans are in place to increase numbers of	care that women most value have been taken account of and have informed the offer available at the proposed maternity hubs as well as the MLUs.

				community midwives and improve ambulance services? Closure of rural MLUs in Shropshire would cause increased pressure on the system, being due to cost cutting and affecting rural women. Sad to learn Ludlow MLU is closing permanently - suggesting other funding routes (tourist tax or crowd funding) Concern about travel time/difficulty from Ludlow or Whitchurch to Shrewsbury or Telford. Lack of communication between neighbouring trusts resulting in inadequate patient	

				safeguarding (based on personal experience of giving birth at Leighton). Proposals leave rural areas at a disadvantage. Open letter from 559 local people - local service users want rural MLUs to remain and believe that plans are dangerous and driven by cost-cutting. Strong disagreement with the statement that 'everyone wants to demedicalise birth' - not everyone wishes to give birth in an MLU. Need equity of provision for rural and urban communities and support retention	

				of rural MLUs. Agree with transfer of care to MLUs including births for low risk women. More homely environment and personalised care in MLUs. Women like to give birth in MLUs, particularly rural MLUs. Inpatient postnatal care in MLUs is most valued by women. Need to promote (rural) MLUs. Many service users have lost confidence in SaTH. Midwives aren't respected by their	

				employer: staff shortages, long working hours, bullying, stress, increased travel times. Specialist care in an obstetric unit is important if things go wrong. Long waits at obstetric unit for delivery bed and being pushed out of postnatal care before feeling ready. Obstetric unit struggling to cope with demand and care for higher risk women being compromised; not enough capacity for postnatal care. Travel and transport costs for partners if inpatient postnatal	

				care at obstetric unit. Fear of travel for women from rural areas while in labour; increased distance, road closures. Increased pressure on ambulance service; ambulance delays. Lack of public transport and increased cost; need to consider travel from home to maternity unit. Need a woman-centred service where women are respected and heard. Rural MLUs need to reopen. Women want an MLU that's open when they	

				go into labour, 24/7. Concern about fast deliveries and unassisted births. On-call arrangements are unrealistic. Support continuity of care model but only if it can be adequately staffed and supported. Need joined up care, closer links with obstetric unit and an allocated obstetrician for each midwife team. MLU midwife teams need structure, support, training and rotation of staff to different environments. Need clear and up-to-	

				date emergency protocols. Need to deal with issues re: cross-border working. Suggest development of MLUs to provide wider range of services e.g. mental health drop-in, peer support groups, mother and toddler groups. Need to improve service delivery in Whitchurch and Market Drayton. Building maternity hubs doesn't reduce need for 24/7 maternity care. Suggest use of pregnancy app.	

				High public concern about quality of Shropshire maternity services; neonatal deaths. Increased risk to mother and baby's health. Need a neonatal ICU in Shropshire. Deliveries in freestanding MLUs fallen much less than MLUs at RSH and PRH. Local support in towns is valued. Midwife-led care perceived less negatively by population. Closure of MLUs in Oswestry and Ludlow is dangerous and	

				unacceptable. Lots of very positive experiences in MLUs, particularly Bridgnorth. Ante- and postnatal care (including overnight stays and help with breastfeeding) in MLUs are important. There will be an increase in postnatal depression if women aren't supported. Bridgnorth is a growing town. Stress of not knowing if MLUs will be open when go into labour. Need to consider women living on border with Worcs	

				who used to go to Kidderminster. Capacity of PRH and RSH to cope with increased demand.	
Telford and Wrekin CCG Board Meeting	9th January 2018	Telford	Members of the public	SaTH has shown no commitment to community midwife services and a balance between the available times of midwives is needed to cover the hubs. Telford and Wrekin has communities who are not able to travel and we need to be careful that these people aren't prejudiced. We need to look at where most births are before there's a decision about the locations. No more than two	A range of factors has been considered in deciding the hub locations including in relation to deprivation, population and access.

				hubs are needed, one in the south of Shropshire and one in the north. They need to be nearest to working class communities and the poorest women who need them most.	
Joint Health Overview and Scrutiny Committee	22nd March 2018	Shrewsbury	Ian Hulme (Shropshire Patients Group)	See section 2.6 above	See section 2.6 above
Midwife-led Unity Review Stakeholder Briefing	24th October 2018	Shrewsbury	7 women who have recently used or are using maternity services	Feedback was not categorised by stakeholder group but overall feedback included: Consider additional/alternative hub locations e.g. Oswestry Need mini hub/outreach services in Oswestry and other rural areas	Hub locations have been evaluated based on need and access. Each hub will have outreach into other areas in line with the particular needs of

				Review travel times and consider public transport Need to consider rural areas and growing populations Need more detail on: 1. Staffing 2. Hub and community services 3. Link to Better Births 4. IT Need improved communication with pregnant women and mothers	that area.
Options Appraisal Workshop 1	6th February 2019	Telford	4 women who have recently used SaTH services	This workshop was about shortlisting the possible options and therefore there was limited feedback given. Feedback was	The views of the clinicians who attended this workshop were used as part of the options

				also not recorded by different groups of people e.g. members of the public.	appraisal process.
Options Appraisal Workshop 2	27th February 2019	Shrewsbury	2 women who have recently used SaTH services	Shropshire is very rural. You are ignoring rural areas. Everything seems to be focussed in the middle of the county. Journey times should be considered e.g. from Ludlow to Shrewsbury. It's easier to look after a lot of people in one building rather than travelling around the	As part of our options appraisal process and the equality impact assessment, we have reviewed the number of women who use the services in the different locations as well as if certain population groups have any specific needs. A travel impact analysis is being completed, which will highlight any issues and we will take these into account. However, our proposed community model means that women will be able to

				county. Most feedback was not recorded by stakeholder group. However, the patients who attended this meeting participated in the feedback that is detailed in section 2.3 above.	receive most maternity care close to their homes. The views of the patients who attended were taken into account as part of the options appraisal process.
Stakeholder workshop – update on options appraisal	29th April 2019	Telford	2 women who have recently used SaTH services (1 from Ludlow and 1 from Telford)	Ludlow – journey time to Shrewsbury, South Shropshire hub wouldn't necessarily have to be in Ludlow You could engage with student midwives at Staffordshire University	The access impact assessment includes two South Shropshire locations (Craven Arms and Ludlow). We will incorporate this in our engagement plan.

Transforming Midwifery Care
in Shropshire, Telford & Wrekin

Shropshire Telford and Wrekin MLU Review

Pre-consultation engagement with Seldom Heard Groups

Introduction

Building on the previous general engagement work in 2017 and 2018, a pre-consultation engagement exercise took place with seldom heard groups in May/June 2019. The purpose of this engagement was to obtain and listen to the views of people who don't normally engage with the NHS to ensure that we were aware of any particular impacts on any particular groups of people that might alter the proposed service model for midwifery-led maternity services.

There was a particular focus on engaging with people who are most likely to be impacted on by the proposed changes and those groups belonging to one or more of the nine protected characteristics as identified through the development of an equality impact assessment. As we are discussing a proposed new service model for midwifery-led maternity services, our main target audience was women who had recently had a baby or those who were likely to have a baby in the near future. These groups were further sub-divided to include:

Age

- Teenage women
- Older women (age 35+)

Gender

- Women

Sexual orientation

- Lesbian and bisexual women of childbearing age

Disability

- Women of childbearing age with a physical disability
- Women of child-bearing age with a learning disability
- Women of child-bearing age with a mental illness
- Women of childbearing age with a sensory impairment
- Women of childbearing age with a long term condition

Race

- BAME women of childbearing age (particularly those born outside the UK and African, African Caribbean, Indian, Bangladeshi and Pakistani)
- Gypsy and traveller women of childbearing age
- New migrants/asylum seekers of child-bearing age
- Non-native speakers of English e.g. Polish women of childbearing age

Religion

- Amish/Mennonite women of childbearing age

In total we spoke to over 170 women of childbearing age as well as some partners and families. These women live in different areas of Shropshire and Telford and Wrekin, including rural areas and areas of deprivation. For example: Shrewsbury, Telford, Oswestry, Newport, Whitchurch, Craven Arms, Ludlow, Bridgnorth, Wellington, Shifnal, Broseley, Wem, Pontesbury, Uffington and Hodnet and their surrounding areas and villages. We also spoke to a small number of women from Powys who were receiving maternity services in Shropshire.

Our approach

Our approach to the seldom heard group engagement work was to first of all identify key groups across Shropshire, Telford and Wrekin ensuring that we groups were identified in different parts of the county including North and South Shropshire as well as more central areas. We also aimed to engage with a mixture of people living in rural and urban areas, as well as people living in more and less affluent parts of the county.

In addition to a focus on the nine protected characteristic groups, we also agreed to try and engage with:

- Women of childbearing age living in a rural area
- Women of childbearing age living in an area of deprivation
- Women working in the military or whose partner works in the military
- Homeless women of childbearing age

After identifying any relevant groups, we made contact with them by telephone and/or email (depending on which contact method was available and publicised.) In many cases, we were obliged to chase on a number of occasions.

When we received a positive response, we explained the purpose of this engagement work and what involvement would entail and wherever possible, we organised to attend any existing meetings that were running during our timescales. If there were no formal meetings to attend within our timescales, we carried out one-to-one meetings, had telephone conversations or circulated information by email.

Due to the challenges we had in organising to attend meetings within the timescales given, we sometimes had to be less targeted in our approach and to attend more general meetings and locations with the hope of meeting some of our target audience.

We produced a form for women to complete, which included some equalities monitoring questions so that we could ensure that we are engaging with as many of the nine protected characteristics (and our other target groups) as possible. We asked for views about maternity services (particularly midwife-led care) and including antenatal and postnatal care as well as the birth. In some cases, where the women's first language wasn't English or they couldn't write in English or we spoke to them on the telephone, we assisted by completing the form for them based on our conversation.

The feedback on the forms was then themed and analysed in relation to the different protected characteristic groups to find out if there were any particular concerns from or impacts on particular groups. The outcomes from this process are summarised in this report below.

Risks and challenges

The main challenge with this piece of work was the short timescale to research groups, make contact and then to attend meetings. This was because the outcomes from the piece of work had to feed into other key documents such as the pre-consultation engagement report, the equalities impact assessment and the pre-consultation business case, which needed to be finalised and approved before the consultation could start. Many groups only meet monthly and sometimes they don't meet during school holidays (particularly mothers with young children); and the most popular groups often have speakers booked some months in advance. The short timescale was further exacerbated by the Whitsun holiday at the end of May; and Ramadan, which made it difficult to meet local Muslim women. We extended our pre-consultation phase slightly in order to enable us to speak to local Muslim women after the Eid celebrations.

In Shropshire (excluding Telford and Wrekin), there is limited diversity in the local population and there has also been limited engagement with seldom heard groups in the past, which makes it very difficult to engage with them quickly. Engagement with these groups is generally a challenge as they are often not motivated to give their views and this can only be overcome by developing long term relationships and by building trust.

Summary of engagement meetings

We contacted all groups listed above that we could identify but some were unable to meet within our timescales, others didn't feel that what we wanted to talk about was relevant to their members and others weren't interested in engaging at all.

The following groups were contacted but we were unable to engage with them within our timescales:

- Women of childbearing age with a sensory impairment
- Gypsy and traveller women

We contacted a number of groups for people with a visual or hearing impairment but unfortunately, the group organisers didn't feel it was relevant for us to attend as all of their members are elderly.

We also attended the gypsy and traveller site in Donnington twice during the pre-consultation period but unfortunately, no women came forward to talk to us.

Some of the other groups we engaged with only included a small number of individuals and therefore the views in this report cannot be regarded as representative of particular groups. It simply gives a general picture of the views of women with different characteristics. Furthermore, the views of people with the same protected characteristic are not always the same as different individuals have different experiences and backgrounds, and they live in different locations, which can impact on the feedback they give us.

The groups that we engaged with and their protected characteristic or characteristics are listed below:

Date/Time	Location	Group	Protected characteristic
Tues 14 May	Telephone conversation	Military women/families	Age – Women of child-bearing age
Fri 17 May	Brookside, Telford	Brookside Central Community Centre	Age - Women of child-bearing age, area of deprivation
Mon 20 May	Princess Royal Hospital, Telford	Women attending the Women's and Children's Centre	Age – Women of child-bearing age
Tues 21 May	Telephone conversation	Christian/Mennonite, South Shropshire	Age – Women of child-bearing age Religion – Christian/Mennonite
Wed 22 May	PRH, Telford	Diabetes clinic	Age - Women of child-bearing age with a LTC
Thurs 23 May	Harlescott, Shrewsbury	Emanuel Church	Age - Women of child-bearing age, Religion – Christian, area of deprivation
Thurs 23 May	Harlescott, Shrewsbury	Bounce and Rhyme Class	Age - Women of child-bearing age, area of deprivation
Wed 29 May	Harlescott, Shrewsbury	Severnfields Medical Centre	Age - Women of child-bearing age, area of deprivation
Wed 29 May	RSH, Shrewsbury	Diabetes clinic	Age - Women of child-bearing age with a LTC
Wed 29 May	Shrewsbury	Shrewsbury Ark	Age - Women of child-bearing age, homeless
Wed 29 May	Shrewsbury	Women with a mental illness	Age - Women of child-bearing age, disability – mental illness
Thurs 30 May	Bridgnorth	Ludlow Baby Sensory	Age - Women of child-bearing age
Fri 31 May	Ludlow	Breastfeeding group	Age - Women of child-bearing age
Sat 1 June	Monkmoor, Shrewsbury	Polish community event	Race - Polish
Mon 3 June	Bridgnorth	Rhyme Times	Age - Women of child-bearing age

Mon 3 June	Shifnal	Rhyme Times	Age - Women of child-bearing age
Mon 3 June	Woodside, Telford	Park Lane Centre	Age - Women of child-bearing age Area of deprivation
Tues 4 June	Sutton Hill, Telford	Hub on the Hill	Age - Women of child-bearing age Area of deprivation
Tues 4 June	Telford	Telford Translate	Age - Women of child-bearing age Race - Polish
Wed 5 June	Brookside, Telford	Re-charge	Age – young women, Race – BAME, area of deprivation
Wed 5 June	Bridgnorth	NCT Bridgnorth bumps and babies	Age – Women of child-bearing age, Religion - Baptist
Wed 5 June	Bridgnorth	Jiggy Wrigglers	Age – Women of child-bearing age
Thurs 6 June	Hodnet, Market Drayton	Hodnet Pre-School Playgroup	Age - Women of child-bearing age, rural area
Thurs 6 June	Snailbeach	Snailbeach playgroup	Age – Women of child-bearing age, rural area
Thurs 6 June	Telford	Telephone conversation with teenage mums	Age – Women of child-bearing age, teenage mums
Fri 7 June	Oswestry	Coffee and Chaos	Age – Women of childbearing age, Religion - Christian
Fri 7 June	Shifnal	Ladybird Tots and Toddlers	Age – Women of childbearing age
Fri 7 June	Telford	Feedback form emailed to One World UK members	Race/Religion – women from different countries
Mon 10 June	Craven Arms	Craven Arms Islamic Centre	Age - Women of child-bearing age, rural area Race/Religion - Islam
Monday 10 June	Shrewsbury	Shropshire Supports Refugees	Age – Women of childbearing age, Race/Religion – Syrian refugees
Mon 10 June	Oswestry	Jools Payne Partnership	Age – Women of childbearing age, Race/Religion – Syrian refugees

Summary of feedback by group

Age

The majority of the women we spoke to were aged 25-39, although we did speak to a small number of women who were younger and older, including a small number or teenage mothers and women over the age of 40. We also spoke to some grandparents who were attending some parent and toddler groups with their grandchildren.

- Younger women

We spoke to a number of younger women during this engagement exercise from the age of 16-24. These women lived in different areas and came from different ethnic backgrounds, to told us that they had a disability. Feedback included that clinicians shouldn't always refer to "partners" as some women are single and that women's views should be respected if they don't want to have a particular treatment. Clear information and consistent advice are valued and it was suggested that more information targeted at teenage mums would be helpful. A few younger women would have liked their partner to have been able to stay longer after the birth and others mentioned a difficulty in getting an initial appointment because they didn't know how to book one. One woman suggested more availability of water births and another commented on a lack of support during labour.

- Older women

We spoke to a number of older women (age 35+) as part of this engagement work, including older women who had recently given birth or who had young children as well as some grandparents and other family members. This age group gave us very similar feedback to women from other age groups and told us that they liked to be seen by the same midwife and that clear and consistent information and advice are important to them. They also value good antenatal and postnatal care, which is available close to where they live. They like to be able to choose where they receive maternity care and want midwives to be friendly and sensitive as well as having the availability to support and advise them. One woman suggested that partners should be involved throughout the maternity process.

Gender

The majority of the people we spoke to as part of this engagement exercise were female. This is because we particularly targeted women of child-bearing age as they are most likely to be impacted on by any changes to maternity services. However, we also spoke to a small number of men who were partners, fathers or other family members.

Sexual orientation

- Lesbian and bisexual women of childbearing age

The majority of the women we spoke to were heterosexual. The small number of lesbian women we spoke to had very similar views to other women. They value continuity of care and good communication and would like care to be available in their local area. One lesbian woman told us that she would like home visits during and after the birth and suggested that a visit to the birth

centre/delivery room before the birth would be useful. Another lesbian woman commented that that she would like midwives to be friendly, sensitive and reassuring and to have time to talk. She also commented about having to travel to see a consultant and to clinics and appointment issues, but this might be more in relation to her being diabetic as opposed to her sexual orientation.

Disability

- Women of child-bearing age with a learning disability

Women with a learning disability told us that they wanted more postnatal support including support with feeding. They also value online and telephone advice and the use of email. One woman with a learning disability living in a rural area expressed a need for local antenatal classes.

- Women of child-bearing age with a mental illness

Women who have a mental illness value many of the same things as other pregnant women and new mothers. They regularly state a need for better mental health support, particularly for postnatal depression. We were also told that maternity and mental health services should be more co-ordinated. Women with a mental illness also value a relaxing and calm environment, with a preference for their own room in a maternity unit. One teenage woman with a mental illness commented on a lack of support during labour.

- Women of childbearing age with a physical disability

We spoke to one teenage woman with a physical disability who told us that she felt judged and that individual views should be respected and treatment not given without approval.

- Women of childbearing age with a long term condition

We spoke to a number of women at diabetes and endocrine clinics in both Telford and Shrewsbury. In addition to comments made by women belonging to other groups, these women also frequently mentioned issues with appointments including availability, cancellations and waiting times. They also told us that access to a diabetes nurse and good support is important to them.

Race

The majority of the women we spoke to were White British, which reflects the demographics of Shropshire. However, we did manage to engage with a small number of women from over 20 different races, including Black, Asian and Minority Ethnic (BAME) women, new migrants and non-native speakers of English. These women were Syrian, Sicilian, Polish, Romanian, Turkish, American, Bangladeshi, African, White and Black Caribbean, Indian, Pakistani, Latvian, Chinese, German, Dutch, Spanish, Welsh, Irish, Arab and Japanese.

The views of these women were broadly similar to other groups. However, a few women mentioned the need for antenatal classes and appointments at different times of the day and the need to encourage more rural/home births. A few women also commented on feeling judged and said that the mother should be listened to and her views respected. One Asian British woman commented on a lack of confidentiality and health matters being discussed in a public area.

The Polish women we spoke to mentioned the importance of continuity of care/carer and of clear information and consistent advice. They also value postnatal care and feel that it's important for clinicians to listen to women and their views. One Polish woman commented on the importance of privacy. The maternity pathway seems to have been slightly different to what women were expecting in England, and to what they are used to in Poland with some women telling us that they wanted an epidural or a caesarean section but they weren't available and that they were expecting a gynaecological examination during their pregnancy as in Poland.

The Syrian refugee women we spoke to tend to have a preference for seeing a consultant rather than a midwife and for a hospital environment as this is what they are used to in their home countries.

Although some of the Syrian women don't speak English, they also told us that health services shouldn't assume that they always need an interpreter, although one would be particularly useful for the first appointment when lots of details need to be given for those who don't speak English well and at scans. It was suggested that it might be helpful if they could take a friend with them to appointments instead of using a hospital interpreter they don't know, particularly a man.

Contrary to the views of many other groups, the Syrian women we spoke to seemed keen to get back home after the birth and to be supported by other women within their community.

Some Syrian women told us that they felt isolated when they were pregnant and had had a baby due to them being a long way away from their families and in some cases, this had led to mental health issues and postnatal depression. Postnatal care for the mother and baby, including mental health support and peer support was seen as very important. They would also appreciate advice and support on what they need to buy for the baby, on the medicines and supplements they can take and on lifestyle management and healthy eating.

As hip fracture in babies is a common hereditary condition in some Syrian families, early diagnosis would be found beneficial.

Religion

The majority of the women we spoke to were Christian, which reflects the demographics of Shropshire. A number of women stated that they have no religion.

In the South of Shropshire, in Lydbury North, there is a small Christian Mennonite community. We spoke to a female representative from this community who told us that the freedom to refuse some services, such as injections or scans is important to them.

We did, however, also speak to women from five other religions: Islam, Sikhism, Buddhism, Hinduism and Judaism. Most of the women from different religious backgrounds gave similar feedback to women from other groups.

The Muslim Syrian refugees we spoke to had some particular feedback relating to their background and religion. Please see the Race section above. In addition, the women we spoke to mentioned that the availability of Halal food was important to them when they were in hospital and that they were used to eating soup only in their home countries just before they gave birth.

The Muslim women we spoke to in Oswestry, Shrewsbury and Craven Arms were all keen to see a female clinician for any planned appointments (but understood that they might have to be looked after by a male clinician in unplanned circumstances.)

Muslim women also told us that privacy is very important to them in the antenatal ward (bay) during the birth and also when breastfeeding. Prayer facilities would also be appreciated in the antenatal area.

Women of childbearing age living in a rural area

Women living in a rural area gave very similar feedback to women living in other areas and to women belonging to groups with different characteristics. They frequently mentioned the importance of having local services as well as continuity of care/carer. Antenatal and postnatal care (including support with feeding) in rural areas were also regarded as very important. They agreed that clear and consistent information/advice and good communication was essential. Peer support and a choice of where to give birth, including encouraging women to give birth at home more and in rural areas, were also highlighted. A few women who live in a rural area said that a visit to the birth centre/delivery room before the birth and home visits during pregnancy and after the birth would be helpful.

Women of childbearing age living in an area of deprivation

Women living in an area of deprivation gave very similar feedback to women living in other areas and to women belonging to groups with different characteristics. Continuity of care/carer is very important as well as friendly and sensitive midwives who have time to talk to pregnant women and new mums. As many other women told us, clear and consistent information and advice and peer support are also valued. Some women also commented on feeling judged and said there's a need to listen to women and to respect their views.

Women working in the military or whose partner works in the military

Feedback from the military wife we spoke to from Donnington in Telford was consistent with feedback from other groups. However, she also mentioned that patient records should be available to clinicians working in different locations.

Homeless women of childbearing age

Feedback from the homeless woman we spoke to who had recently had a baby suggests that the system doesn't work for people with chaotic lives and that there needs to be more flexibility and more joined-up working between health and social care. The woman also felt that her emotional needs had been neglected, she felt judged and hadn't always felt supported.

Conclusion

Most of the women and families we spoke to as part of this pre-consultation engagement exercise belonging to different groups and living in different areas shared similar views about maternity services and in particular about midwife-led services. The majority of the women we spoke to told us that they were very happy with the maternity care they had received.

The key things that women told us are important to them are:

- Continuity of care/carer
- Provision of information/good support and advice/consistent messages/clear communication
- Friendly midwives who reassure and are sensitive; and who have time to talk
- More appointment availability, shorter waiting times and fewer cancellations
- Postnatal care including support with feeding and better mental health support
- Local care and available in more locations, for example consultant clinics and scans
- Choice of where to give birth
- Availability of online and telephone advice; email communication
- Home visits during pregnancy and after birth
- Antenatal care, especially in rural areas
- Peer support

Travel and transport and the associated costs weren't mentioned as often as we would have expected in this engagement exercise. This may be a reflection on the number of maternity services that are already available locally.

However, some groups also have their own specific needs as highlighted above. Notably, for example, the preference of Muslim women to receive care from a female consultant due to their religious beliefs and the way maternity care is delivered in their home countries.

Women living in certain areas also tended to have some similar views regardless of their protected characteristic(s), for example, women living in Oswestry, Bridgnorth and Ludlow liked to be able to access a midwifery-led service locally.

Most of the feedback received during this engagement exercise was very similar to the feedback given during the general engagement work in 2017.

Outcomes from this pre-consultation engagement work with seldom heard groups will feed into the development of the proposed model and the consultation.

When the proposed model is approved, further engagement will take place with our seldom heard groups in Shropshire and Telford and Wrekin as part of a formal public consultation to ensure that there is no disproportionate or differential impact on people belonging to one or more of the nine protected characteristic groups.

Transforming Midwifery Care
in Shropshire, Telford & Wrekin

NHS

Equality Impact Assessment, Stage 1, June 2019

Version Control

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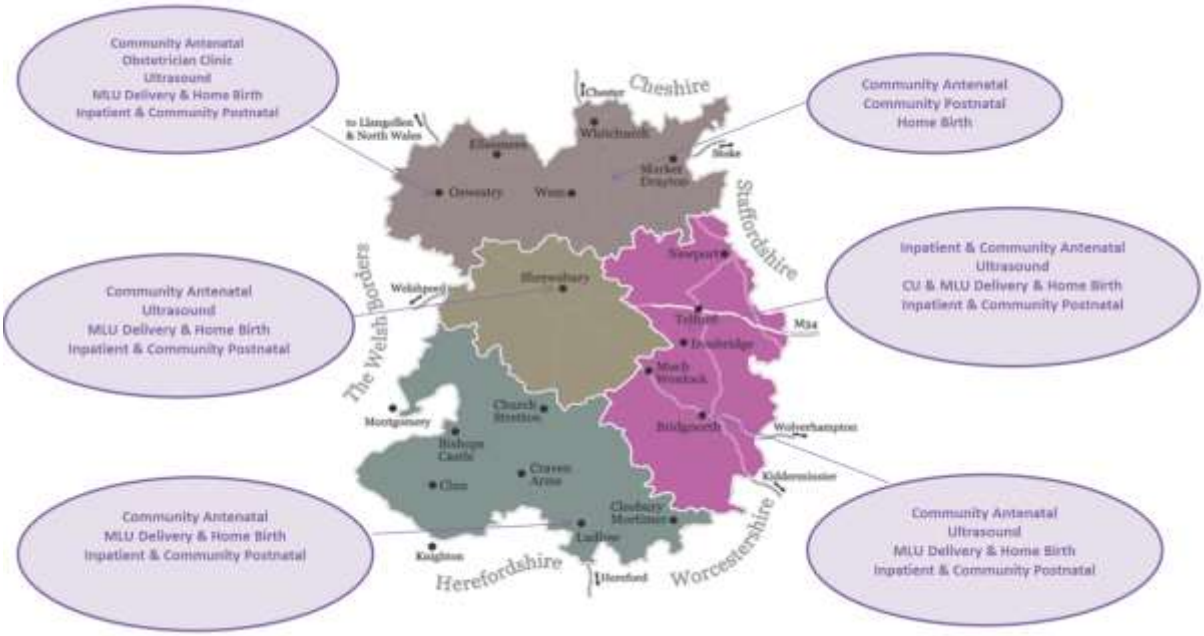
Contents

1.0 Introduction

In Shropshire, Telford and Wrekin, the following services are currently available to pregnant women and mothers of newborn babies:

- 4 midwife-led units (MLU) in Bridgnorth, Oswestry, Ludlow and Shrewsbury
- 1 consultant-led unit at Princess Royal Hospital in Telford
- 1 co-located midwife-led unit at the Princess Royal Hospital
- 2 community bases in Whitchurch and Market Drayton



There is a disparity in the services available to women in different parts of the county as shown in the diagram above.

These services deliver care to women during pregnancy, at birth and after their baby is born. Around 5,500 women access maternity services in Shropshire, Telford and Wrekin each year, with around 5,000 births each year. These maternity services are delivered by The Shrewsbury and Telford Hospital NHS Trust (SaTH.) Around 80 staff work in the midwife-led units.

Maternity care is a key priority in terms of commissioning for women and children in Shropshire, Telford and Wrekin and in the broader Shropshire Telford and Wrekin Sustainability and Transformation Plan (STP). Better Births – a nationally mandated five-year local maternity system transformation programme is underway. However, local action to better meet patient needs is required.

There have been a number of high profile adverse events in the area, which has heightened public awareness and scrutiny of local maternity care. There has also been a high level of media interest, with emotive headlines in local and national newspapers and lots of feedback, including emails from the public supporting MLUs.

Following intermittent closures starting in 2016, due to staffing pressures, the Trust made the decision to withdraw births and inpatient postnatal stays at the MLUs in Bridgnorth, Ludlow and Oswestry on the grounds of safety in July 2017. These MLUs have been open for planned care only for 18 months.

In January 2019, following the Future Fit public consultation, the Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs) made the decision to locate the women and children's consultant-led services, including maternity services, on the Royal Shrewsbury Hospital site. Both the Shrewsbury and Telford hospital sites will continue to have 24-hour midwife-led units where low risk women will be able to give birth and access antenatal and postnatal appointments and scanning. Women's, children's and neonatal outpatient appointments will also take place at both hospitals. These changes are expected to be in place by 2023-24. The new proposed model of midwifery care takes these changes into account.

In June 2019, the SaTH board took the decision to temporarily close the MLU at the Royal Shrewsbury Hospital for up to six months in order for essential building works to take place. Women booked in to give birth at this MLU were offered a birth at the MLU or the consultant-led unit at the Princess Royal Hospital in Telford. Home births were not affected. All antenatal and postnatal appointments, including scans continued to be provided at the Royal Shrewsbury Hospital.

These proposals affect all pregnant women and potentially all women of child-bearing age registered with GPs in Shropshire and Telford and Wrekin as well as a small number of women from neighbouring areas. We understand that there may be higher impacts on certain groups due to the type of service being considered for change and these impacts are described in relation to each of the nine protected characteristics later in the document.

1.1 Case for change

Maternity care policy has remained consistent since 2007 on the need for women to be offered choice regarding place of birth in England, to specifically include Midwife Led Units (MLUs), both alongside and freestanding as well as provision for home birth care. Since 2014, the NICE intrapartum guidelines have recommended MLUs for low risk women because they reduce labour and birth interventions, notably caesarean section rates. In 2016, 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.

- Personalised care
- Continuity of carer

- Safer care
- Better postnatal and perinatal mental health care
- Multi-professional working
- Working across boundaries
- A fair payment system

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:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movement
- Effective fetal monitoring during labour

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.

On a local level, there is a disparity in the current services available to women in the different parts of Shropshire, Telford and Wrekin, which means that pregnant women and mothers with newborn babies are receiving different levels of care depending on where they live. We want to make the services available to women more equitable no matter where they live in the county.

The demographic and health profile of women living within the different localities in our county is changing. There is an increasing number of women of child-bearing age in certain areas and a decrease in others. The age profile of pregnant women has also changed in recent years and there has also been an increase in certain lifestyles and conditions, which can lead to poorer outcomes, for example, obesity and diabetes.

The number of women giving birth in a midwife-led unit is declining. 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). This is due to a steady increase in women who require a higher level of care that is available through a consultant unit birth.

A recent Birthrate Plus report in April 2017 indicated 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 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. Feedback from our pre-consultation engagement work with staff working in the midwife-led units also told us that they feel that currently, we don't have the correct staffing model. 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.

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.

In feedback to Healthwatch in 2016/17, women and their partners reported 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.

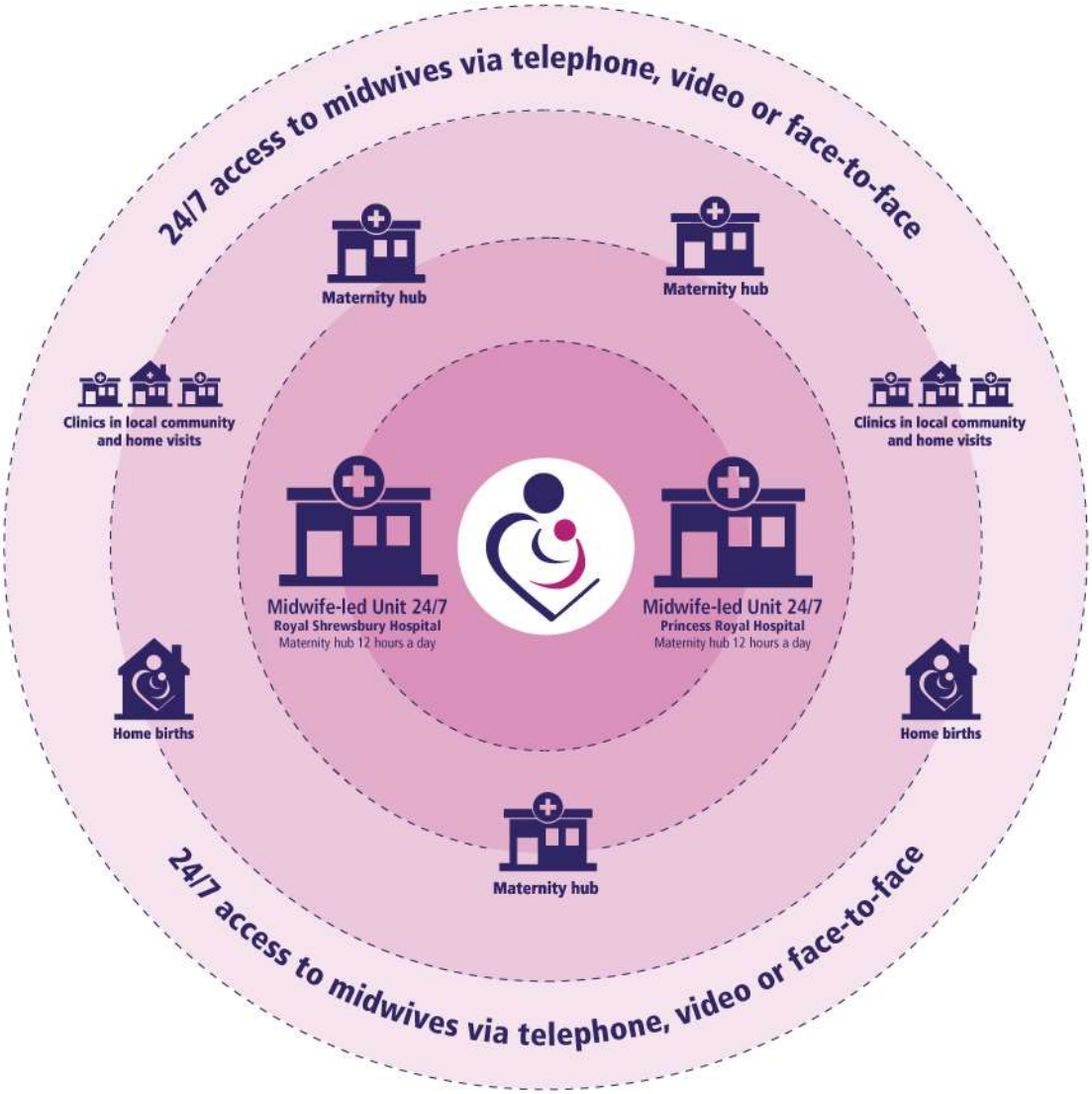
The Shropshire maternity services usage survey in 2017 identified that distance from home and continuity of carer are very important to women when choosing where to give birth. Women identified in-patient postnatal care as being very important to them.

1.2 Proposed model

The CCGs are proposing to transform the way that midwifery care is currently delivered across Shropshire, Telford and Wrekin to provide all women with safe, high quality and personalised care throughout their pregnancy (antenatal care), during the birth and following the birth of their baby (postnatal care).

The CCGs propose to do this by creating a network of midwife-led units, maternity hubs and clinics delivered in the local community and at home. Midwives and maternity support workers will work flexibly across this network, providing personalised care to women throughout all stages of their pregnancy, birth and beyond.

Proposed model of midwifery care



We are proposing to replace the existing three rural midwife-led units in Oswestry, Bridgnorth and Ludlow with xx new maternity hubs. These will be located in xx and be open 12 hours a day, every day. At every hub, women will be able to access the same full range of care. During their pregnancy women will be able to access care from a midwife and maternity support worker as well as being able to access a range of other services, including scans and obstetrician appointments. Following the birth of their baby, women and their families will be able to access care from a midwife or maternity support worker from the hub as well as getting help and advice with feeding and caring for their baby. A range of other health services will also be available to women throughout their pregnancy and beyond to help keep them and their baby healthy. This includes support with emotional and mental health as well as services to help women to be fit and healthy during pregnancy and beyond.

The Midwife-led Units (MLUs) at the Royal Shrewsbury Hospital and the Princess Royal Hospital will continue to be available 24 hours a day, 7 days a week. As well as offering the same services as the Maternity Hubs for 12 hours a day every day, women will continue to be able to give birth at an MLU, providing they don't need a higher level of care which will be available at the Consultant-led Unit.

The midwife led units will not have postnatal beds. This means that following birth, women will receive the postnatal care they need in the community, through their midwife or maternity support worker visiting them at home. In addition, they will be able to access a range of postnatal care at their local maternity hub or clinic. For the small number of women who need a higher level of care, they will receive this in the postnatal ward at the Consultant-led Unit.

Routine antenatal and postnatal appointments with midwives will continue to take place in local communities across the county in GP practices and children's centres and in a woman's home. Under our proposal, maternity support workers will be more involved in providing routine antenatal and postnatal care.

Women will continue to be able to choose from a full range of settings in which to give birth: consultant-led unit at the Princess Royal Hospital, alongside MLU at the Princess Royal Hospital, freestanding MLU at Royal Shrewsbury Hospital and home birth. Women will not be able to give birth at the maternity hubs.

Add in more on proposed option/s once confirmed

2.0 Equality and impact

2.1 What is meant by equality?

Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways. Our age, disability, faith or belief, gender, race, sexual orientation, being married or in a civil partnership, being transgender or being pregnant should not disadvantage us. These different characteristics are protected under the Equality Act 2010.

We also recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

2.2 Legislation and guidance

Public sector organisations have a duty to adhere to legislation that relates to decision making by public bodies to ensure they make decisions that meet the health and social care needs of communities. The key legislation is:

- The Public Sector Equality Act – Section 149 of the Equality Act 2010
- The Health and Social Care Act (2012) 14T Duties as to reducing inequalities
- The NHS Constitution
- Brown Principles
- Additional duties to consult in Wales are set out in the 'The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to:

a. eliminate discrimination, harassment and victimisation,
b. advance 'Equality of Opportunity', and
c. foster good relations.

The Health and Social Care Act (2012) 14T introduced a new duty on the Secretary of State, NHS England and clinical commissioning groups to 'have regard to the need to reduce inequalities' between patients with respect to:

- their ability to access health services and
- the outcomes achieved for them by the provision of health services.

The Brown Principles have been detailed in case law to help support organisations to meet these duties:

- The organisation must be aware of their duty.
- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.
- This formal consultation will fulfil part of our consideration of our legal duty

The equality impact assessment needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.

Full information on legislative requirements can be found in Appendix 3.

2.3 Equality Impact Assessments

In order to demonstrate that a public sector body has given due regard to the general duty, public sector bodies are required to conduct an equality impact assessment (EIA) of their policies and decisions, which are likely to have an impact upon people with protected characteristics.

The purpose of a consultation EIA is to answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?

3.0 The approach to the EIA development

An iterative approach to producing this EIA has been taken. The following shows the stages of previous and planned development:

- Stage one allows us to define the proposal for change and the rationale behind it, consider the expected outcomes, who would be impacted and how we would engage with people belonging to one or more of the nine protected characteristics. The purpose is to describe our understanding at an early point in the process of any likely impact, rather than being a definitive statement of the impact of the proposed changes. In this stage, we identify and address any gaps in our knowledge by engaging and consulting with the public and stakeholders.
- Stage two allows us to undertake consultation activity with the public, stakeholders and seldom heard groups through to a mid-point review. Activity is analysed, initial themes from feedback and discussion assessed to identify any gaps from earlier pre-consultation activity. We gather additional knowledge and comments from a range of groups representing the nine protected characteristics. This stage informs the activity for reaching seldom heard groups in the second half of the consultation.
- Stage three encompasses the post consultation analysis and presents the findings of the public consultation alongside the impact analysis. The purpose is to provide those making the decision with information about how people belonging to one or more of the nine protected characteristics may be disproportionately impacted on and what potential mitigations may be required to address any impacts that have been identified. The general duty cannot be delegated, so it is incumbent upon each CCG to demonstrate they have assessed how the MLU review may impact on their service users and the wider public in the area.
- A Stage four final analysis document is produced once the decision on the proposal has been made. This document will present the final decision, the reasons behind the decision, outline

any proposed mitigations, and describe how the implementation of the MLU service review will be monitored and reviewed.

A range of different data sources have been used in this document. There might be a small variation in this data but this does not make a material difference to the proposal or the recommendations.

4.0 Pre-consultation engagement

Extensive pre-consultation engagement work has taken place with patients and staff working in midwife-led units in Shropshire, Telford and Wrekin over the last few years.

In addition to the feedback gathered over the past year, the following sources of existing patient feedback have been used to inform the proposed new model of care:

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

In feedback to Healthwatch, women and their partners report positively in particular with regard 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.

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.

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.

In 2017, a detailed engagement exercise took place to understand what people perceive is adding value and contributing to positive outcomes for both staff and families; what is working well and what is getting in the way of improved care and family outcomes as well as community priorities for change and improvement.

132 parents took part including 108 women from rural areas and 24 women who live in urban settings. 85 staff also shared their views including midwives women's care assistants, health visitors, GPs and obstetricians.

Based on participant's 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 who have 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.

Themes from completed forms, feedback submitted via email/letter and feedback from seven co-design workshops are included in the ELC Programme final report "Review of Maternity Services in Shropshire Telford and Wrekin: staff, family and community perspectives." This report can be found here: https://www.shropshireccg.nhs.uk/media/1059/final-insight-report.pdf

On 24 October 2018, a Midwife-Led Unit (MLU) Review stakeholder briefing took place which was attended by over 60 people. This included people involved in the MLU Review decision-making process (27), working in midwifery led services (26), those who have recently used or are using maternity services (7) and other people who didn't fit into any of these specified groups (2).

The workshop aimed to provide a reminder of the rationale for the review, what's happened so far to bring everyone up to date, what the evidence is telling us and describe what local clinicians believe is the vision for the future.

There was one main group exercise during the day where attendees were asked to feedback on the proposed new service, ideas for improvement, and if there was anything missing. There was also the opportunity to inform the consultation plan with group work on helping to inform target audiences and methods of communication.

Detailed outcomes from this workshop can be found in:
https://www.shropshireccg.nhs.uk/media/2129/engagement-report-from-mlu-review-stakeholder-briefing-24-october-18.pdf

Additional pre-consultation engagement work was undertaken with seldom heard groups in 2019. There was a particular focus on engaging with people who are most likely to be impacted on by the

proposed changes and those groups belonging to one or more of the nine protected characteristics as identified in this equality impact assessment. As we are discussing a proposed new service model for midwifery-led maternity services, our main target audience was women who had recently had a baby or those who were likely to have a baby in the near future. These groups were further sub-divided to include:

Age

- Teenage women
- Older women (age 35+)

Gender

- Women (of childbearing age)

Sexual orientation

- Lesbian and bisexual women of childbearing age

Disability

- Women of childbearing age with a physical disability
- Women of child-bearing age with a learning disability
- Women of child-bearing age with a mental illness
- Women of childbearing age with a sensory impairment
- Women of childbearing age with a long term condition

Race

- BAME women of childbearing age (particularly those born outside the UK and African, African Caribbean, Indian, Bangladeshi and Pakistani)
- Gypsy and traveller women of childbearing age
- New migrants/asylum seekers of child-bearing age
- Non-native speakers of English e.g. Polish women of childbearing age

Religion

- Amish/Mennonite women of childbearing age

Over 170 women, partners and families took part in the pre-consultation engagement exercise with seldom heard groups. We used a variety of engagement tools including a questionnaire, attending existing meetings, having a stand in a public area for example in hospital waiting rooms, one-to-one meetings and telephone conversations.

Overall, the feedback was very similar across all of the different groups, with a small number of exceptions which are highlighted below.

The key things that women told us are important to them are:

- Continuity of care/carer
- Provision of information/good support and advice/consistent messages/clear communication
- Friendly midwives who reassure and are sensitive; and who have time to talk
- More appointment availability, shorter waiting times and fewer cancellations
- Postnatal care including support with feeding and better mental health support
- Local care and available in more locations, for example consultant clinics and scans
- Choice of where to give birth
- Availability of online and telephone advice; email communication
- Home visits during pregnancy and after birth
- Antenatal care, especially in rural areas
- Peer support

However, some groups also have their own specific needs, for example, the preference of Muslim women to receive care from a female clinician and for privacy while giving birth and while breastfeeding. Halal food and prayer facilities were also important to the Muslim women we spoke to.

The Syrian refugee women we spoke to tend to prefer to see a consultant rather than a midwife and to receive care in a hospital environment as this is what they are used to in their home country.

Although some of the Syrian women don't speak English, they also told us that health services shouldn't assume that they always need an interpreter, although one would be particularly useful for the first appointment when lots of details need to be given for those who don't speak English well and at scans. It was suggested that it might be helpful if they could take a friend with them to appointments instead of using a hospital interpreter they don't know, particularly a man.

Some Syrian women we spoke to seemed keen to get back home after the birth and to be supported by other women within their community, if there were other Syrian women living nearby. Other women told us that they felt isolated when they were pregnant and had had a baby due to them being a long way away from their families and in some cases, this had led to mental health issues and postnatal depression. Postnatal care for the mother and baby, including mental health support and peer support were seen as very important. They would also appreciate advice and support on what they need to buy for the baby, on the medicines and supplements they can take and on lifestyle management and healthy eating. As hip fracture in babies is a common hereditary condition in some Syrian families, early diagnosis would be found beneficial.

For Polish women, the maternity pathway seems to be slightly different in England to what they are used to in Poland, with some women telling us that they wanted an epidural or a caesarean section but they weren't available and that they were expecting a gynaecological examination during their pregnancy as in their home country.

A female representative from the small Christian Mennonite community in South Shropshire told us that the freedom to refuse some services, such as injections or scans is important to them.

Feedback from younger women included that clinicians shouldn't always refer to "partners" as some women are single and that women's views should be respected if they don't want to have a particular treatment. It was suggested that more information targeted at teenage mums would be helpful. A few younger women would have liked their partner to have been able to stay longer after the birth and others mentioned a difficulty in getting an initial appointment because they didn't know how to book one. One woman suggested more availability of water births and another commented on a lack of support during labour.

We spoke to one teenage woman with a physical disability who told us that she felt judged and that individual views should be respected and treatment not given without approval.

Women with a learning disability told us that they wanted more postnatal support including support with feeding. One woman with a learning disability living in a rural area expressed a need for local antenatal classes.

Women who have a mental illness regularly stated a need for better mental health support, particularly for postnatal depression. We were also told that maternity and mental health services should be more co-ordinated. Women with a mental illness also value a relaxing and calm environment, with a preference for their own room in a maternity unit. One teenage woman with a mental illness commented on a lack of support during labour.

We spoke to a number of women with a long term condition at diabetes and endocrine clinics in both Telford and Shrewsbury. These women frequently mentioned issues with appointments including availability, cancellations and waiting times. They also told us that access to a diabetes nurse and good support is important to them.

The military wife we spoke to suggested that patient records should be available to clinicians working in different locations.

Feedback from the homeless woman we spoke to who had recently had a baby suggests that the system doesn't work for people with chaotic lives and that there needs to be more flexibility and more joined-up working between health and social care. The woman also felt that her emotional needs had been neglected, she felt judged and hadn't always felt supported.

Women living in certain areas also tended to have some similar views regardless of their protected characteristic(s), for example, women living in Oswestry, Bridgnorth and Ludlow liked to be able to access a midwifery-led service locally. A few women who live in a rural area said that a visit to the birth centre/delivery room before the birth and home visits during pregnancy and after the birth would be helpful. Some women living in an area of deprivation commented on feeling judged and said there's a need to listen to women and to respect their views.

Most of the feedback received during this engagement exercise was very similar to the feedback given during the general engagement work in 2017.

The feedback from the seldom heard group engagement exercise in 2019 was from a relatively small number of women and their families and should not be regarded as representative of particular protected characteristic groups although it can be useful to give an indication of potential impacts.

In addition to direct engagement with the public and particularly with people belonging to one or more of the nine protected characteristics outlined above, from the start of the midwife-led service review, our local Healthwatch and voluntary sector organisations have also been involved. We worked closely with voluntary and community organisations to enable us to contact the people they work with during our pre-consultation work with seldom heard groups. More detailed information can be found in the pre-consultation engagement report (add weblink.)

Significant engagement has also taken place with clinicians locally to develop the proposed clinical model. This has included GPs, midwives, women's support assistants, obstetricians, neonatal nurses and consultants and healthcare assistants. A broad mix of clinicians based in different parts of the county have also been involved in a number of stakeholder meetings and workshops, including the options appraisal workshops. Clinicians including GPs and secondary care clinicians have also been involved due to their membership of the CCG governing bodies and the Midwife-led Review Programme Board.

Non-clinical staff working in our two local clinical commissioning groups, Shropshire CCG and Telford and Wrekin CCG, and our local provider organisations, including the Shrewsbury and Telford Hospital NHS Trust, have regularly been kept up-to-date about the midwife-led unit review through their organisations' normal communications channels such as e-newsletters and face-to-face staff briefings.

Regular updates have also been given at Board meetings where directors and other members of staff have been present. Some non-clinical staff have also taken part in the engagement work that has taken place with staff working in or associated with the midwife-led units. Commissioners of maternity services, communications and engagement staff, the local maternity system programme lead, the Maternity Voices Partnership development co-ordinator and a project support officer are all involved in the Midwife-led Review Programme Board.

More detail on all of the pre-consultation engagement can be found in the pre-consultation engagement with seldom heard groups report and the pre-consultation engagement report (add weblinks when available.)

5.0 The consultation and reaching seldom heard groups

Building on the pre-consultation engagement work with seldom heard groups in May/June 2019 and working again with voluntary and community organisations, a detailed plan has been developed to obtain the views of people belonging to one or more of the nine protected characteristics on the

proposed model for midwife-led care in Shropshire, Telford and Wrekin in September and October 2019.

We used a flexible approach with a variety of engagement tools to enable as many people as possible to give us their views and this included attending existing meetings and events, one-to-one meetings and telephone conversations depending on the preferences of the people we were engaging with.

Our aims are to:

- Make sure our methods and approaches are tailored to specific audiences as required
- Identify and use the best ways of reaching the largest amount of people and providing opportunities for those within the nine protected characteristics to respond
- Work with the voluntary and community sectors to share information and to engage with groups of people who don't usually tell us their views
- Provide accessible documentation, including Easy Read, large print Word document and Word document for use with screen readers, as well as a screen reader-compatible survey
- Offer accessible formats including translated versions or interpreter facilities where required
- Have due regard for Equality and Diversity, ensuring that the consultation works to understand how people's differences, cultural expectations and social status can affect their experiences, health outcomes and quality of care.
- Monitor consultation responses to ensure the views reflect the whole population and adapt activity as required.
- Use different methods or direct activity to reach certain communities where we become aware of any under-representation.
- Arrange our meetings so they cover the local geographical areas that make up Shropshire, Telford & Wrekin.
- Arrange meetings in accessible venues and offer interpreters, translators and hearing loops where required.

Add in details of the consultation and how seldom heard groups were involved.

Add key themes by protected characteristic

6.0 Profile of the affected population

Due to the nature of the services that are being considered for change, the groups most likely to be impacted on are women of childbearing age and their partners and families.

In 2015, there were 47,400 (30.2%) women of childbearing age (16-44) in Shropshire and 31,300 (36.3%) in Telford and Wrekin. In Shropshire, there are an average of 3400 conceptions each year and in Telford and Wrekin, 2615. It is estimated that 2700 (5.8%) women of childbearing age live in an area of deprivation in Shropshire and 8900 (28.6%) in Telford and Wrekin.

Source: Improving Outcomes for Maternity Services in Shropshire and Telford and Wrekin 2017 - 2021

SaTH Maternity Services Births 2016/17				
Maternity Unit	**Shropshire patients**	**Telford and Wrekin patients**	**Powys patients**	**Patients from other areas**
Consultant Unit	2016	1830	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
Home	41	21	1	1
Born after arrival (without presence of midwife or obstetrician)	8	8	2	8
Total	**2490**	**2060**	**219**	**159**

During 2016-17, over 4,000 women had a consultant-led birth at the Women's and Children's Centre at Princess Royal Hospital and almost 650 women gave birth in one of the midwife-led units.

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

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).

The most popular midwife-led units for giving birth were the Shrewsbury and Wrekin MLUs, with the alongside MLU at the Princess Royal Hospital having more than double the number of births than the next most popular MLU in Shrewsbury.

Between April 2016 and March 2018, compared to the county average, the percentage of pregnant women on an intermediate/intensive care pathway for antenatal care is highest in Hadley Castle, The Wrekin, Hadley South and Shrewsbury and Atcham meaning that women from these areas will have a higher need to access maternity services before they give birth. The same areas also have the highest percentage of women on an intermediate/intensive care pathway for postnatal care in addition to North Shropshire.

The antenatal pathway is based on information collected at the antenatal assessment appointment (usually undertaken at about 10 weeks' gestation) when the health and social care risk assessment is carried out. Risk factors such as obesity, smoking, diabetes, hypertension, substance misuse and domestic abuse are considered. The postnatal pathway follows the same format as the antenatal pathway based on three levels: standard, intermediate and intensive. The level is usually assigned after the women has had her baby and is based on her health and care characteristics.

Between 2015/16 and 2017/18, the areas with the highest percentage of women who had pre-term births were South Shropshire and Lakeside South and those who had the most complicated deliveries and co-morbidities were from South Shropshire and Bridgnorth.

Over the same period, the rate of obesity in pregnancy was higher than the Shropshire average in Oswestry, Lakeside South, Hadley Castle, The Wrekin and Shrewsbury and Atcham. Rates of smoking at the time of delivery were highest in North Shropshire, Lakeside South, The Wrekin, Hadley Castle, Oswestry and Shrewsbury and Atcham.

The percentage of women living in Shrewsbury and Atcham consuming alcohol in pregnancy was higher than in other parts of the county in 2015/16 – 2017/18 and there was a higher rate of substance misuse by pregnant women living in Lakeside South and South Shropshire than in other parts of the county.

During this same period, pregnant women living in North Shropshire, Lakeside South and South Shropshire were more likely to access mental health services than women living in other parts of the county.

The proportion of women who started to breastfeed their babies was lowest in The Wrekin, Lakeside South, Hadley Castle, North Shropshire and Shrewsbury and Atcham in 2015/16-2017/18.

At this time, The Wrekin, Lakeside South, Hadley Castle, Shrewsbury and Atcham, Oswestry and North Shropshire had a higher percentage of women aged 16-44 living in the most deprived areas than the county average.

Source: Midwife Led Unit Review Stakeholder Workshop Stage 3 Data Pack 31/1/19

6.1 Age

In 2017/18, the locality with the largest number of women child-bearing age (16-44) was in Shrewsbury and Atcham – 15,457. The localities with the smallest number of women of child-bearing age were Oswestry (6,130) and South Shropshire (6,805.) If the total number of women in the same age range living three Telford and Wrekin localities is calculated, this equates to over double this figure – 34,024.

Female Population aged 16-44 Years Registered with a Shropshire, Telford and Wrekin GP 2017/18	
Locality	Females aged 16-44
Bridgnorth	7.840
Hadley Castle	12,307
Lakeside South	8,437
North Shropshire	10,080
Oswestry	6,130
Shrewsbury and Atcham	15,457
South Shropshire	6,805
The Wrekin	13,280

Source: GP practice data

Across all localities, the most women who accessed maternity services and who gave birth were in the 20-24, 25-29 and 30-34 age groups. A relatively small number of teenage women and older

women (age 45+) accessed maternity services and gave birth across Telford and Wrekin and Shropshire in 2016/17.

Teenage pregnancy rates have decreased considerably since the late 1990s. In 2015, only 3.4% of all live births in England and Wales were to mothers aged under 20. There are also low rates of conception among under 18s in Telford and Wrekin and Shropshire – although in Telford and Wrekin, this is above the national average. The highest conception rates are in the most deprived wards.

The areas with the most under 16 year old women who had a baby in 2016/17 were from Hadley Castle and Lakeside South (with 1 birth in each.)

The localities with the highest number of births to women in the 16-19 year age group were Lakeside South (35), Hadley Castle (31) and Shrewsbury and Atcham (30.) Only three teenagers from South Shropshire and seven from Bridgnorth gave birth during the same period.

Although the number of women giving birth in the 40-44 year age group was relatively small compared to other age groups (167 in total), the locality with the highest number of births was Shrewsbury and Atcham with 36.

The number of women over the age of 45 giving birth is even lower with the highest number of births was to women living in The Wrekin (3), followed by two women in each of the following areas: Hadley Castle, Lakeside South, Oswestry and Shrewsbury and Atcham.

There were no deliveries to women under the age of 16 or over the age of 45 living in Bridgnorth, North Shropshire or South Shropshire in 2016/17. *Source: Shrewsbury and Telford Hospital Trust maternity activity data 2016/17*

For more detail on the breakdown of deliveries by age and locality, please see Appendix 1.

6.2 Disability

Data on rates of disability/long term conditions indicates that across Shropshire and Telford and Wrekin, rates are higher than the England rate. Rates are slightly lower for people living in Telford and Wrekin. However, this data relates to long term conditions which may not include people with a learning disability or a mental health problem.

According to the 2011 Census, the locality with the most women with a disability is Shrewsbury and Atcham (9139) and the locality with the lowest number of women with a disability is Oswestry with 3982.

Data relating to disability is not routinely collected by The Shrewsbury and Telford Hospital NHS Trust. We are therefore unable to make an overall assessment of if there is variation in the number of women with a disability living in different parts of the health economy who access maternity services.

6.3 Gender reassignment

There are no national or local government statistics available on gender reassignment. The Gender Identity Research and Education Society (GIRES) estimates that one per cent of the population is transgender.

Data relating to gender reassignment is not collected by The Shrewsbury and Telford Hospital NHS Trust and therefore we are unable to assess if there is variation in the number of people who have undergone or are undergoing gender reassignment treatment living in different parts of the health economy who access maternity services.

6.4 Marriage and civil partnership

The percentage of married people living in Shropshire is above the England average but lower for Telford and Wrekin. The rate of same sex civil partnerships is generally low for England. The rate for civil partnerships is lower than the England rate for Shropshire and Telford and Wrekin.

Data relating to marital status is not consistently collected by The Shrewsbury and Telford Hospital NHS Trust and therefore we are unable to assess if there are different levels of marital status in different parts of the health economy and different levels of access to health services.

From the information we do have, the highest number of women who gave birth in Shropshire and Telford and Wrekin in 2016/17 were single, with Shrewsbury and Atcham (534), Hadley Castle (410) and Lakeside South (382) having the highest number of single women having a baby. The locality with the highest number of married women or those in a civil partnership who gave birth in the same year was Shrewsbury and Atcham with 304 deliveries. The total number of single women giving birth (2408) was over double the total number of married women or women in a civil partnership (1100) who gave birth in 2016/17.

However, this data should be regarded with caution as for a large number of women (1120), their marital status has not been recorded.

For more detail on deliveries by marital status and locality, please see Appendix 1.

6.5 Pregnancy and maternity

In Shropshire, Telford and Wrekin women have the choice whether to give birth in the consultant-led unit, in one of the midwife-led units or at home (if they are not classed as high risk.)

More women from Shropshire (2016) gave birth at the consultant-led unit than women from Telford and Wrekin (1830) in 2016/17. The vast majority of births were in relation to Shropshire, Telford and Wrekin patients although a small number of women came from neighbouring areas.

The introduction to this section and the description of the “Age” characteristic provide more information about the women of child-bearing age in our health economy.

6.6 Race

Both Shropshire and Telford and Wrekin are predominantly White British and have a higher percentage of White British people than the England rate. This is therefore reflected in the ethnic background of the local women giving birth, with over 80% of women saying that they were White in 2016/17.

There is a higher percentage of Black, Asian, Minority and Ethnic groups (BAME) in Telford and Wrekin compared to Shropshire, with the localities of Hadley Castle (5421) and The Wrekin (4898) having the most female BAME residents (source: 2011 Census.) However, all groups have a lower percentage than the England rate apart from "Mixed/Multiple Ethnic Groups: White and Black Caribbean" which is slightly higher.

It is therefore unsurprising that the localities with the highest number of births to BAME women are in Telford and Wrekin. The localities with the highest number of births to Asian or Asian British women in 2016/17 were Hadley Castle and the Wrekin and the highest number of births to Black women were to women from The Wrekin, Lakeside South and Hadley Castle. The home location for the number of births to Mixed/Multiple Ethnic women was slightly different with the highest number coming from Hadley Castle followed by Shrewsbury and Atcham. Overall most BAME women who gave birth in the county in 2016/17 lived in Hadley Castle and The Wrekin.

However, this data should be regarded with caution as for some women who accessed maternity services (648), their ethnicity has not been recorded.

For more detail on deliveries by race and locality, please see Appendix 1.

6.7 Religion or belief

Across Shropshire, Telford and Wrekin there is some variation in religion and belief. Compared to the England rate, the number of people of Christian belief is higher than other religions in both areas. For other religions such as Hindu, Muslim and Sikh, the rates are significantly lower than the England rates. There is a significantly higher number of people with different religions living in Telford and Wrekin than in Shropshire. The localities of Hadley Castle and The Wrekin have the highest number of non-Christian females, with 1649 and 1509 respectively (*Source: 2011 Census*.)

Christianity, Church of England and Catholicism are most frequently recorded as being the religion of women giving birth in our county. Islam is the most frequently recorded non-Christian religion, with the Hadley Castle and The Wrekin having the highest number of women giving birth of this faith. The Sikh religion is also most prevalent amongst women who have a baby living in Hadley Castle and The Wrekin.

However, this data should be regarded with caution as for some women who gave birth in 2016/17 (491), their religion or belief has not been recorded. 2009 women also stated that they had no religion.

For more detail on deliveries by religion or belief and locality, please see Appendix 1

6.8 Sex

Male and female populations across Shropshire, Telford and Wrekin are in line with the England population rates. There is a slightly higher female than male population across both areas.

6.9 Sexual orientation

Sexual orientation is not asked for by the Census, however Stonewall estimates that the LGBT population in England is between 1.5 to 5.85 per cent. The Office for National Statistics estimates that the number of LGBT people as part of the general population in England and Wales is 1.7 per cent.

Additional information from Stonewall indicates that younger age groups are more likely to disclose that they are gay compared to older people.

Source: https://www.stonewall.org.uk/sites/default/files/lgbt_in_britain_home_and_communities.pdf

Data relating to sexual orientation is not collected by The Shrewsbury and Telford Hospital NHS Trust and therefore we are unable to assess if there is variation in the number of LGBT people living in different parts of the health economy who access maternity services.

6.10 People living in a rural area

Overall Shropshire is a rural county with around 66% of the population living in what is classified as a rural area. Around 34% of the population resides in areas classed as being urban. Much of the south west of Shropshire is classified as being sparsely populated. Telford and Wrekin has a more urban profile. The rural area of Telford and Wrekin is to the west of Telford town centre and although this is the largest area of the Borough, it has the lowest population density at 0.7 people per hectare.

6.11 People living in an area of deprivation

The proportion of women aged 16-44 living in the most deprived quintile (IMD 2015) is higher in Oswestry, North Shropshire, Shrewsbury and Atcham, The Wrekin, Hadley Castle and Lakeside South than in South Shropshire and Bridgnorth localities. *Source: MLU Review options appraisal stage 3 data pack*

Telford and Wrekin has higher levels of deprivation overall than Shropshire. According to Government statistics, a total of 15 areas in Telford and Wrekin are ranked in the 10% most deprived nationally, in the wards of Woodside (x4), Malinslee and Dawley Bank (x3), Madeley and Sutton Hill (x2), Brookside (x2), Hadley and Leegomery, Dawley & Aqueduct and College. The 2015 picture of the most deprived areas in Telford and Wrekin looks very similar to 2010 with new areas in Haygate, Park and Dothill and additional areas in Hadley and Leegomery and The Nedge. More than a quarter (27%) of the Borough's population lives in the 20% most deprived areas nationally, an increase on 24% in 2010.

People living in Shropshire are relatively more affluent compared with the national average. However, there is also significant rural deprivation in parts of Shropshire, with access to transport and higher costs for everyday essentials being a challenge for people particularly in the far south and north of the county. All of the most deprived areas in Shropshire are in urban areas, with the five highest ranked being in Harlescott (Shrewsbury), Monkmoor (Shrewsbury), Ludlow East, Oswestry South and Meole/Bayston Hill, Column and Sutton. All nine Shropshire LSOAs that fall within the 20% most deprived in England are located within urban areas of the county. Harlescott is the only area that falls within the 10% most deprived nationally.

7.0 Potential impacts on the protected characteristic groups

This section provides details of the potential impacts that have been identified on each of the protected characteristics as a result of the proposed options. Appendix 3 provides descriptions of the protected characteristics.

We have not produced a separate analysis for each of the protected characteristic groups by each of the proposed options. This decision has been made on the grounds that the type of impact does not change between options for the protected characteristics, although the extent of the impact may differ. The main difference in impact between the options is geographical - where people live is a greater indicator of the impact rather than their protected characteristic.

Most pregnant women and mothers of newborn babies would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. The positive benefits would be increased for particular groups of women who may need to access these services more due to increased risk factors. However, for women currently living near to a MLU where they can give birth and their families, if births are no longer possible in this location, there may be a slight negative impact if they have to travel further to a birthing unit.

7.1 Women

All of the people who will be directly impacted on by changes to maternity services will be women. However, there may also be an impact on partners, carers and families who could be of either gender who attend appointments with the mother-to-be/mother and/or who are present at the birth.

Women are more dependent on public transport than men and it is therefore anticipated that any additional travel to maternity services is likely to impact more on women. In 2011, 79% of men held a full driving licence compared to 65% of women and one in five men compared to one in three women do not drive. *Source: National Travel Survey, Department of Transport, 2012*

There could also possibly be an adverse impact on both men and women from deprived communities and rural communities because of issues of public transport, location and low income. However, as our most deprived communities are in Telford and Wrekin, there would be a positive impact on women if they are able to access more services from a community hub closer to their homes. There would also be a positive impact on women living in North Shropshire if more services are available to them locally.

Overall, most pregnant women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

7.2 Women in different age groups

By their nature, any changes to maternity services are most likely to impact on pregnant women, mothers and their babies. Women of child-bearing age would therefore be most impacted on by these proposals and in particular younger and older women of child-bearing age.

In 2015, 21.5% of all live births in England and Wales were to mothers aged 35 or over. Mothers in this age group are more likely on average to experience complications during pregnancy, labour and postnatal. Older age in mothers is also associated with higher rates of perinatal mortality as is the likelihood of foetuses with congenital anomalies and admissions of neonates to intensive care.
As older women are more likely to have complications during pregnancy and childbirth and are likely to need more pre-and postnatal care, they are more likely to be impacted on by any changes to maternity care.

A Save the Children report in 2012 highlighted that girls under the age of 15 are five times more likely to die in pregnancy than women in their 20s, and that babies born to younger mothers are also at greater risk. Teenagers are also less likely to get pre-natal care soon enough compared to older women and are susceptible to a number of conditions including high blood pressure and pre-eclampsia. Although numbers in the UK are low, under 18s are more likely to give birth to premature babies and low birth weight babies and have complications during labour.

The World Health Organisation adds: “the emotional, psychological and social needs of pregnant adolescent girls can be greater than those of other women.” Source: https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

As teenage women are more likely to have complications during pregnancy and childbirth, they are likely to need more pre- and postnatal care and therefore, they are more likely to be impacted on by any changes to maternity care.

Most pregnant women of all ages would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

However, the level of impact on the different age groups may be increased if they live in rural and/or deprived areas. A change in location of services may have an impact on travel access, time and cost for some women and their families. This could represent a particular challenge for women who don't drive and who need to travel by public transport. Research for the Campaign for Better Transport (2013) explored how changes in UK government funding have impacted on young people, including increasing debts, high usage of public transport, low car usage, and increased transport costs.

As the proposed model is a community one, bringing many services closer to women's homes, there is likely to be an overall positive impact in terms of travel time and cost. However, for women currently living near to a MLU where they can give birth, if births are no longer possible in this location, there may be a slight negative impact on younger women if they have to travel further to a birthing unit. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

7.3 Women with a disability

There is a higher number than the national average of patients with a longer-term condition living in all Shropshire, Telford and Wrekin. In Shropshire there are 10.2% (31,258) people who have a long-term condition/disability where activities are limited a little compared to 9.6% (15.935) in Telford and Wrekin. Disabled people make up a significant percentage of the population (*ONS Census 2011data: 9.5 million people have a limiting long-term illness or impairment*) and we know that disabled people are likely to use health services more frequently than non-disabled people, although monitoring data is not as well developed as it is for race, gender and age.

Disabled people with other equality characteristics can face multiple disadvantages. For example, some ethnic groups have a higher proportion of the population who are disabled. 25% of people in both White Irish, and White gypsy and traveller groups are disabled.

Source: Care Quality Commission 2013 Disability and Ethnicity Equality Counts

General research relating to women with a learning disability (LD) has found that they can face significant barriers to accessing NHS services, which can contribute to them being less likely to use services, and more likely to access maternity care later in pregnancy. In addition, people with LD experience higher rates of co-morbidity including physical and mental health problems than those who do not have a LD and these increase their risks when pregnant, particularly as they may be unable to follow advice on prevention or self-care. *Source: Department of Health 2004*

A study reporting on the use of maternity services by women with a disability in 2010 concluded that women with a disability were at higher risk for adverse pregnancy outcomes; for example, they were more likely to deliver early and have low-birth-weight babies. However, it also concluded that some women, such as those with a physical disability, appropriately received more care. *Source: M, Malouf R, Gao H, et al Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period. BMC Pregnancy Childbirth 2013;13:174.doi:10.1186/1471-2393-13-174*

Disabled women are usually classified during their pregnancy as 'high risk' requiring more antenatal visits and more scans, however, arranging these intensive appointments can be difficult for some

disabled women. *Source: Mitra M, Clements KM, Zhang J, et al. Maternal characteristics, pregnancy complications, and adverse birth outcomes among women with disabilities. Med Care 2015;53:1027–32.doi:10.1097/MLR.0000000000000427*

Barriers to accessing healthcare for disabled people include transport issues, accessing information and communication can create significant barriers to accessing healthcare services for people with sensory loss or learning disability. In Great Britain, 74% of adults with impairments experienced restrictions in using transport compared with 58% of adults without impairments *Source: ONS Life Opportunities Survey 2009/10*

Research by the Office for Disability Issues (2009) found: Lack of access to a car is a significant issue for disabled people and their families and results in much greater reliance upon public transport services. Data from the Omnibus Survey (2004) suggested that disabled people were more than twice as likely to have no access to a car in the household than non-disabled people (35.3% of those defined as having health conditions that limited activity or work compared to 14% without.)

Overall, most women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

However, public transport, particularly from rural areas, might represent a real challenge for a woman with a disability if she had to travel further. A carer might also need to accompany her to maternity appointments to offer help and support.

Sources: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/health-and-care-of-people-with-learning-disabilities-experimental-statistics-2016-to-2017; https://www.england.nhs.uk/learning-disabilities/

Some disabled women may not feel confident in using public transport even if it is physically possible for them to do so. Challenges can include luggage blocking wheelchair access, attitudes of the public and drivers and communication for people with a learning disability. This situation could be exacerbated for a pregnant, disabled woman.

As the proposed model is a community one, bringing many services closer to women's homes, there is likely to be an overall positive impact in terms of travel time and cost. However, for women currently living near to a MLU where they can give birth, if births are no longer possible in this location, there may be a slight negative impact on women with a disability and their partners and families if they have to travel further to a birthing unit. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

7.4 Gender reassignment

Care for people undergoing gender reassignment falls under Interim gender dysphoria protocols 2013/14 which is commissioned by NHS England. Previous engagement with this group has highlighted a lack of understanding by healthcare staff around gender transition and patients' preferences as to how they wished to be treated.

The proposals do not directly impact people undergoing any core gender reassignment treatments, however this assessment acknowledges that this group is often disadvantaged within healthcare due to a general lack of understanding of transgender issues. Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

7.5 Women who are married or in a civil partnership

Marriage and Civil Partnership protection applies for employment and we have found minimal evidence to suggest that people who are married or are in a civil partnership are disproportionately impacted on in relation to the proposed changes to maternity services.

Overall, most women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

The only possible negative impact could be for single women who don't have a partner to help them if they needed to travel further to appointments, however, the same could apply to married women or those in a civil partnership if their partner is working or is unable to take them to appointments for another reason. This situation could be exacerbated for women who don't drive or who are more reliant on public transport due to possible increased travel times and costs to travel to appointments.

As the proposed model is a community one, bringing many services closer to women's homes, there is likely to be an overall positive impact in terms of travel time and cost. However, for women currently living near to a MLU where they can give birth, if births are no longer possible in this location, there may be a slight negative impact on single women who don't drive or who are reliant on public transport if they have to travel further to a birthing unit. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

7.6 Maternal women

This protected characteristic applies to all women who access maternity services and therefore all women of child-bearing age and their partners and families would be impacted on by any changes to these services. The impacts of the proposed service changes on women with other protected characteristics are described in the other sections.

Previous engagement work has told us that accessing maternity services can be a challenge for pregnant women, particularly if they do not have family or friends nearby and during labour. This problem could be exacerbated for pregnant women living in deprived and/or rural areas due to possible increased travel costs and times.

However, overall, most women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the

community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. There would particularly be a positive impact on women living in North Shropshire and women living in some of the more deprived areas of Telford.

In terms of access, the impact of the proposed change on the total maternal population can be confirmed once the proposals in relation to hub sites are confirmed.

7.7 Women of different races

There is much evidence of different levels of risk to women from different ethnic backgrounds in relation to pregnancy and childbirth. Black, Asian and Minority Ethnic women and children, for example, have an increased risk of some poor outcomes:

- stillbirth – babies of African-Caribbean and African mothers have more than double the risk of stillbirth, and babies of Indian, Bangladeshi and Pakistani mothers have an increased risk, compared with babies of White mothers *Source: CMACE, 2011; Gardosi, 2013*
- low birthweight – Indian, Pakistani and Bangladeshi babies are 2.5 times more likely than White babies to have a low birthweight, and Black Caribbean and Black African babies are 60% more likely to have a low birthweight *Source: Kelly, 2008*
- preterm birth – babies of African -Caribbean and African mothers are at increased risk compared to babies of mothers of other ethnic origins *Source: Aveyard et al, 2002; Office for National Statistics, 2016*
- congenital abnormalities – babies of mothers of born in India and Bangladesh are at increased risk and babies of mothers born in Pakistan are three times more likely than babies of mothers born in the UK to be born with a congenital abnormality *Source:* Blarajan et al, 1987
- severe maternal morbidity – Black and Minority Ethnic women are 50% more likely than White women to suffer severe maternal morbidity, and the risk is more than double for women of African and Afro-Caribbean origin *Source: Knight et al, 2009*
- maternal death – Black mothers are four times more likely to die in pregnancy or in the year after birth than White mothers Source: Knight et al, 2016
- late booking for antenatal care - women of South Asian origin are likely to initiate care later and have fewer antenatal visits than white women; women who are asylum seekers or refugees are disproportionately represented within unbooked births *Source: Rowe & Garcia, 2003*

Black, Asian and Minority Ethnic women are also less likely to have positive experiences of maternity care. The National Maternity Survey *(Redshaw & Henderson, 2015)* found that, compared with White women, they were:

- less likely to have the first antenatal contact by 12 weeks, less likely to be offered antenatal classes, less likely to feel they had enough information about their choices for maternity

care, less likely to feel they were always involved in decisions about antenatal care, and less likely to feel their midwives were always respectful

- less likely to feel they were always involved in decisions during labour and birth, and less likely to have always had trust and confidence in staff during labour and birth
- more likely to have a postnatal stay in hospital of more than three days but less likely to feel they were always treated with respect by hospital staff.

All of the above factors could mean that women from the ethnic backgrounds mentioned above could have an increased need for ante- and postnatal maternity care.

Research published by the RNIB has highlighted differences between ethnic populations in the risk of developing sight complications, which in turn may affect the ability of these groups to access healthcare. See the section about Disability for more information.

Otherwise there is no evidence to suggest that people from BAME communities would be disproportionately impacted on in relation to travel and transport. However, for BAME people living in areas of deprivation or rural areas, there may be a negative impact in relation to access to public transport and travel costs. This would mainly be in relation to the place of giving birth which may, for some groups, be located further away than it is currently.

Some women from the Oswestry area give birth in Wales, in Wrexham. Women from Powys only access consultant-led care through SaTH and not midwife-led care. There would therefore be no impact in relation to these proposals for changes to midwife-led care on Welsh women or women who are possibly Welsh speakers.

Most pregnant BAME women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. As most of our local BAME communities are in Telford, there would be a positive impact on these women if there is an additional community hub closer to where they live.

7.8 Women of different religions or beliefs

Generally, we have found no evidence to suggest that women who have different religious beliefs are at a higher or lower risk of certain conditions, which may mean they would have to access maternity services more. The only exception to this is the small Mennonite/Amish community (approx. 20 people) living in South Shropshire. This community may be more prone to genetic disorders, increased birth defects and a higher infant mortality rate than the overall population.

If this community lives in an area of deprivation and/or a rural area, there may be slight a negative impact in relation to access to public transport and travel costs. This would mainly be in relation to the place of giving birth which may be located further away than it is currently. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

However, most pregnant women from all religions and beliefs would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. As most of our local women with non-Christian religions live in Telford, there would be a positive impact on these women if there is an additional community hub closer to where they live.

7.9 Lesbian or bisexual women

Due to lifestyle choices, such as smoking and drinking, pregnant lesbian and bisexual women may be at increased risk of complications during pregnancy. They may therefore have an increased need to access pre- and postnatal maternity services.

Lesbians are more likely to have smoked and to drink heavily than women in general. At various ages they are less likely to have had a smear test. Half have had negative experience of healthcare within the last year alone and a similar number feel unable to be open about their sexual orientation to their GP. *Source: Stonewall Prescription for change, Lesbian and Bisexual women's health check 2008*

LGBT people have:

- poorer experiences of hospital care – with poorer respect of individual rights
- poorer access to health and social care provision: gay women may be less likely to access primary care services than their heterosexual counterparts.
- are particularly subjected to stigmatisation, discrimination and insensitivity.

Research shows that access to health and social care for the LGBT community is problematic and that underlying causes stem from a general lack of awareness of LGBT needs and assumptions made about social and sexual practices, often leading to treatments and screenings to be negated or not deemed necessary.

There are a number of reports which highlight the issue of LGBT communities feeling unsafe when using public transport especially young LGBT people. This could potentially make it more of a challenge for lesbian and bisexual women to access maternity services, particularly if they are unable drive or have access to a car and have to use public transport. This would mainly be in relation to the place of giving birth which may be located further away than it is currently.

However, overall, most pregnant lesbian and bisexual women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. In particular, lesbian and bisexual living in North Shropshire and the more deprived areas of Telford would be positively impacted on by the proposed changes.

7.10 Women living in a rural area

Research carried out by the Local Government Association and Public Health England documented in Health and Wellbeing in Rural Areas (2017) notes that current national data collection on deprivation currently masks pockets of small communities that are deprived.

Although it is accepted that living in rural communities can have many positive health benefits, there are a range of issues raised within the above research. This national information is useful in understanding the needs in rural communities and in summary includes:

- Poverty – 15 per cent of households in rural areas live in poverty, compared to 22 per cent in urban areas
- Housing – Costs tend to be higher and fuel costs are also higher
- Employment – More likely for some communities to be reliant on seasonal work and lower than national average wages
- Access to transport – Travel distance to services may be longer and public transport links may be poor. Economic pressures on local authorities often results in reductions to services
- Population – Populations living in rural areas tend to be older and from White British backgrounds compared to urban areas
- Lack of national understanding of health issues relating to rural communities, however current data shows that health is generally better for people in rural areas compared to urban areas.
- Attitudes to seeking health advice and help differs in rural areas
- Primary care services are important in promoting preventative and screening services to promote health.

The research also acknowledges that rural deprivation is not fully identified compared to urban deprivation and that work is underway to develop a fairer comparison of deprivation indices.

Most women living in rural areas would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

From our engagement work, we have heard that people in rural communities have challenges in relation to travel and transport. The biggest obstacle can often be getting from their home to their nearest public transport and not necessarily travelling by public transport itself, although this can often have limited availability and times are not always suitable for appointment times. The situation could be exacerbated for a small number of younger pregnant women who are less likely to have access to a car, particularly if they are on a low income and/or don't have friends and family living nearby who could give them a lift. Also, women with a disability, women from some ethnic backgrounds and lesbian or bisexual women may need to access maternity services more due to increased pregnancy risks and complications.

Although the main rural areas relate to Shropshire, it should be noted that there are also rural areas within Telford and Wrekin that are poorly served by public transport.

There may be slight a negative impact on women living in some rural areas in relation to access to public transport and travel costs if they have to travel further to an MLU than they do currently. This would mainly be in relation to the place of giving birth which may be located further away than it is currently and the impact would mainly be on low risk women as high risk women would already go to the consultant-led unit. However, there would be a positive impact on women living in rural areas of North Shropshire if there is an additional community hub and local services closer to where they live than exist currently.

7.11 Women living in an area of deprivation

There is a higher prevalence of many behavioural risk factors among women living in the more deprived areas. For example, in more deprived areas, the prevalence of inactivity and the prevalence of smoking are both highest, while the proportion of people eating the recommended 5-a-day of fruits and vegetables is lowest. People in the most deprived areas are also more likely to suffer the harms associated with alcohol consumption.

The level of risk for people living in an area of deprivation also belonging to a particular protected characteristic group could be increased. For example, a higher proportion of those in Asian and Black ethnic groups do not eat the recommended amount of fruit and vegetables and have a higher rate of inactivity. Smoking is more common among White and Mixed ethnic groups and being overweight is higher in White and Black ethnicities.

Furthermore, the infant mortality rate is highest in the most deprived areas. The level of risk of infant mortality could be increased by a woman's ethnic background. For example, Pakistani, Black African and Black Caribbean women have an infant mortality rate higher than the England average, with Pakistani infant mortality rates the highest.

These health inequalities are underpinned by inequalities in the broad social and economic circumstances which influence health.

Source: https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health

This evidence suggests that as a result of the factors outlined above, women living in deprived areas can have more health needs, which may lead them to access maternity services more and have poorer health outcomes.

Women living in areas of deprivation may be positively or negatively impacted on by these proposals depending on where they live. Although Telford and Wrekin has the most areas with high levels of deprivation, there are also areas of deprivation in Shropshire and rural deprivation, as outlined above, is a challenge for people living in parts of Shropshire. The impact would be greater on pregnant women/new mothers and families on low incomes, particularly those who don't drive or

have access to a car or without family living nearby who can help with transport. This would mainly be in relation to the place of giving birth which may be located further away than it is currently.

As the main areas of deprivation where patients live are in Telford and Wrekin, there could be a potential negative impact for pregnant women and their families living in these areas if they had to travel further to access maternity services than they do now. There would also be an additional negative impact on older and younger women, women with a disability, lesbian and bisexual women and some BAME communities living in these areas who are likely to be more frequent users of maternity services. However, as the proposal would be for an additional community hub to be based in Telford and Wrekin close to these areas of deprivation, this impact is more likely to be a positive one.

Overall, most pregnant women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

For people living in deprived rural areas, the impacts are described in the previous section.

8.0 Conclusion/considerations

At the start of this EIA, we stated that we wanted to answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?

We have identified that certain groups of people do have different needs, experiences, issues and priorities in relation to maternity services, and specifically, midwife-led services. These are outlined in sections 4 and 7 above. However, overall, due to the community model that is being proposed and local services being available depending on the needs of women, there will be a positive impact on most women. The proposed model will also promote equality across the whole of the county as women will be able to generally access the same level of service, particularly ante- and postnatal care wherever they live. This isn't always the case currently. There will possibly be a negative impact on women who are currently living near to the existing rural MLUs where they can give birth, if they are no longer able to do so and therefore have to travel further. This will, however, mainly impact on women who are classed as low risk as anyone who has certain risk factors (like a long term condition, or is particularly young or old) would already have to travel to give birth in the consultant-led unit. In addition, if the hubs are not located in the same locations as the existing MLUs, some women might need to travel further to access some services.

Information to be added at the end

9.0 Recommendations

Pre-consultation recommendations

- Build on the pre-consultation engagement work with seldom heard groups and ensure that the views of people belonging to one or more of the protected characteristic groups on the proposed model are obtained (the key groups likely to be impacted on are highlighted earlier in this document and in the pre-consultation engagement with seldom heard groups report.)
- Produce consultation materials in different languages and formats, including Easy Read.
- Use interpreters at meetings and events if required.
- Attend existing meetings of groups in their own area, with people they know and where they are more likely to feel comfortable to talk.
- Adapt the engagement tools used to engage with seldom heard groups depending on their availability and needs, for example, a telephone conversation might be easier for someone who finds it difficult to travel and some people might prefer a one-to-one meeting rather than giving their views in front of other people.
- Don't make assumptions about the people you are engaging with; not all women have a partner or a male partner. All women have different backgrounds and experiences and should be treated as individuals.
- Including images of women from different protected characteristic groups is also important when producing the consultation materials as women are less likely to respond if they feel the consultation isn't relevant to them.
- Use clear and consistent language that's easy for people to understand in the consultation materials.
- Investigate ways to improve cross-border and out-of-county communications between healthcare providers; ensure that maternity services in surrounding areas are engaged as part of the consultation process.

Consultation recommendations

Information to be added at the end

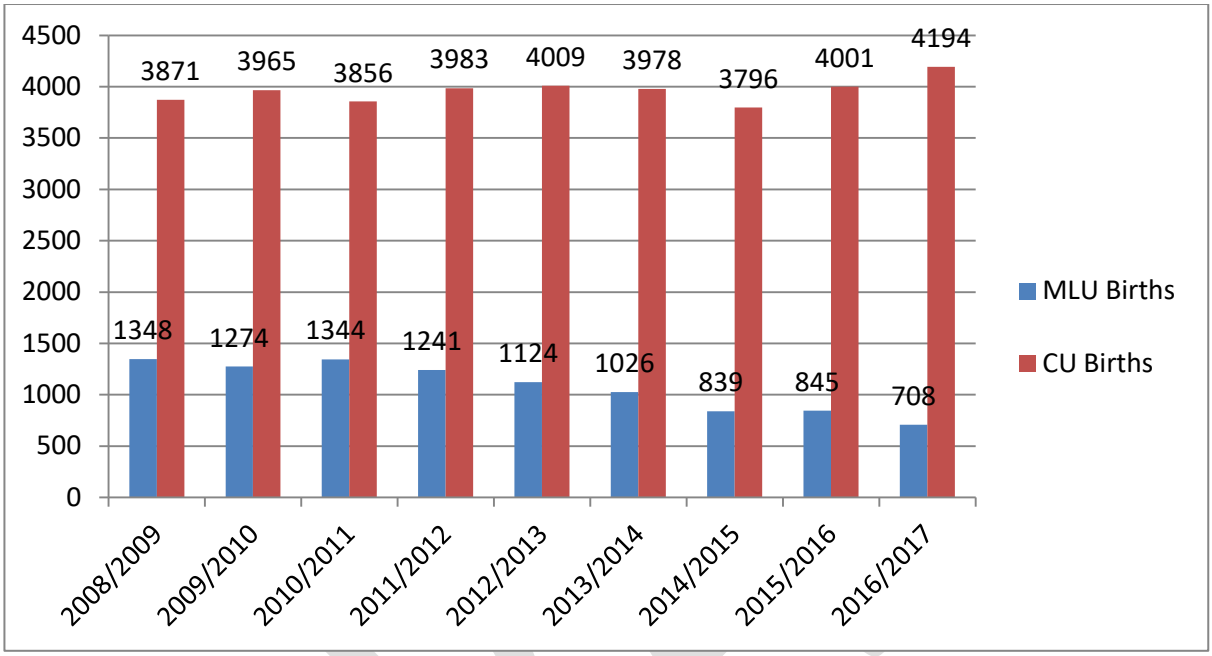
Post-consultation recommendations

Information to be added at the end

10.0 Appendices

Appendix 1: SaTH Birth Data

Shrewsbury and Telford Hospital NHS Trust - Summary Birth Figures 2008-2017



Number of deliveries at Shrewsbury and Telford NHS Trust in 2016/17 by protected characteristic and locality

1. Age

Number of deliveries by age and locality

Age	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Below 16	<10	-	<10	-	<10	-	<10	-	<10	-	0	-	<10	-	<10	-	<10	-	<10	-
16-19	170	4%	<10	-	31	4%	35	6%	21	4%	<10	-	30	3%	<10	-	23	4%	<10	-
20-24	908	19%	78	18%	172	21%	160	26%	92	19%	41	18%	165	16%	40	16%	109	18%	51	14%
25-29	1454	30%	119	27%	246	30%	198	32%	137	28%	73	33%	308	30%	84	34%	173	29%	116	31%
30-34	1390	29%	150	34%	224	27%	140	23%	145	30%	57	26%	311	30%	82	33%	176	29%	105	28%
35-39	736	15%	71	16%	126	15%	66	11%	73	15%	29	13%	181	18%	27	11%	95	16%	68	18%
40-44	167	3%	14	3%	18	2%	19	3%	22	4%	<10	-	36	3%	13	5%	17	3%	18	5%
45-49	11	0.2%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Age not stated	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Total	4849	100%	439	100%	821	100%	621	100%	490	100%	222	100%	1034	100%	250	100%	597	100%	375	100%

Source: SaTH activity data for maternity services 2016/17

2. Ethnicity

Number of deliveries by ethnicity and locality

Ethnicity	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	4031	83%	354	81%	628	76%	510	82%	430	88%	192	86%	951	92%	218	87%	444	74%	304	81%
Asian/Asian British	137	3%	<10	-	41	5%	<10	-	<10	-	<10	-	18	2%	<10	-	46	8%	<10	-
Mixed/Multiple Ethnic	87	2%	<10	-	23	3%	17	3%	<10	-	<10	-	20	2%	<10	-	17	3%	<10	-
Black	49	1%	<10	-	17	2%	11	2%	<10	-	<10	-	<10	-	<10	-	14	2%	<10	-
Other	19	0.4%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Not stated	526	11%	72	16%	109	13%	72	12%	49	10%	24	11%	36	3%	30	12%	73	12%	61	16%
Total	4849	100%	439	100%	821	100%	621	100%	490	100%	222	100%	1034	100%	250	100%	597	100%	375	100%

Source: SaTH activity data for maternity services 2016/17

3. Religion or belief

Number of deliveries by religion or belief and locality

Religion or belief	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Agnostic	22	0.5%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Atheist	100	2%	33	8%	<10	-	13	2%	12	2%	<10	-	18	2%	<10	-	<10	-	<10	-
Baptist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Buddhist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
catholic	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Catholic (Roman)	342	7%	31	7%	95	12%	40	6%	29	6%	<10	-	70	7%	<10	-	49	8%	11	3%
Christian	780	16%	75	17%	143	17%	93	15%	105	21%	45	20%	143	14%	38	15%	98	16%	40	11%
Church of England	825	17%	127	29%	104	13%	72	12%	110	22%	53	24%	189	18%	54	22%	82	14%	34	9%
Church of Scotland	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Church of Wales	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Evangelic	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Greek Orthodox	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Hindu	14	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
humanist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Islam	115	2%	<10	-	35	4%	<10	-	<10	-	<10	-	16	2%	<10	-	40	7%	<10	-

Jehovahs Witness	16	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Jewish	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Mennonite Christian	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Methodist	21	0.4%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Mormon	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
None	2009	41%	134	31%	358	44%	353	57%	175	36%	70	32%	506	49%	101	40%	258	43%	54	14%
None and christian	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
None and church of england	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Orthodox	22	0.5%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Other	16	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
pagan	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Protestant	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Sikh	36	1%	<10	-	15	2%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
spiritual	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Spiritualist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Religion not stated	491	10%	22	5%	37	5%	25	4%	37	8%	27	12%	60	6%	34	14%	23	4%	226	60%
Total	4849	100%	439	100%	821	100%	621	100%	490	100%	222	100%	1034	100%	250	100%	597	100%	375	100%

Source: SaTH activity data for maternity services 2016/17

4. Marital status

Number of deliveries by marital status and locality

Marital status	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Single	2408	50%	196	45%	410	50%	382	62%	222	45%	106	48%	534	52%	113	45%	297	50%	148	39%
Married/Civil Partner	1100	23%	100	23%	157	19%	91	15%	145	30%	48	22%	304	29%	53	21%	129	22%	73	19%
Separated	21	0.4%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Divorced/Person whose Civil Partnership has been dissolved	16	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Widowed/Surviving Civil Partner	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Not known	181	4%	<10	-	15	2%	<10	-	15	3%	<10	-	115	11%	<10	-	<10	-	12	3%
Not applicable	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Question remains unanswered	1120	23%	138	31%	230	28%	134	22%	106	22%	62	28%	70	7%	80	32%	159	27%	141	38%
Total	4849	100%	439	100%	821	100%	621	100%	490	100%	222	100%	1034	100%	250	100%	597	100%	375	100%

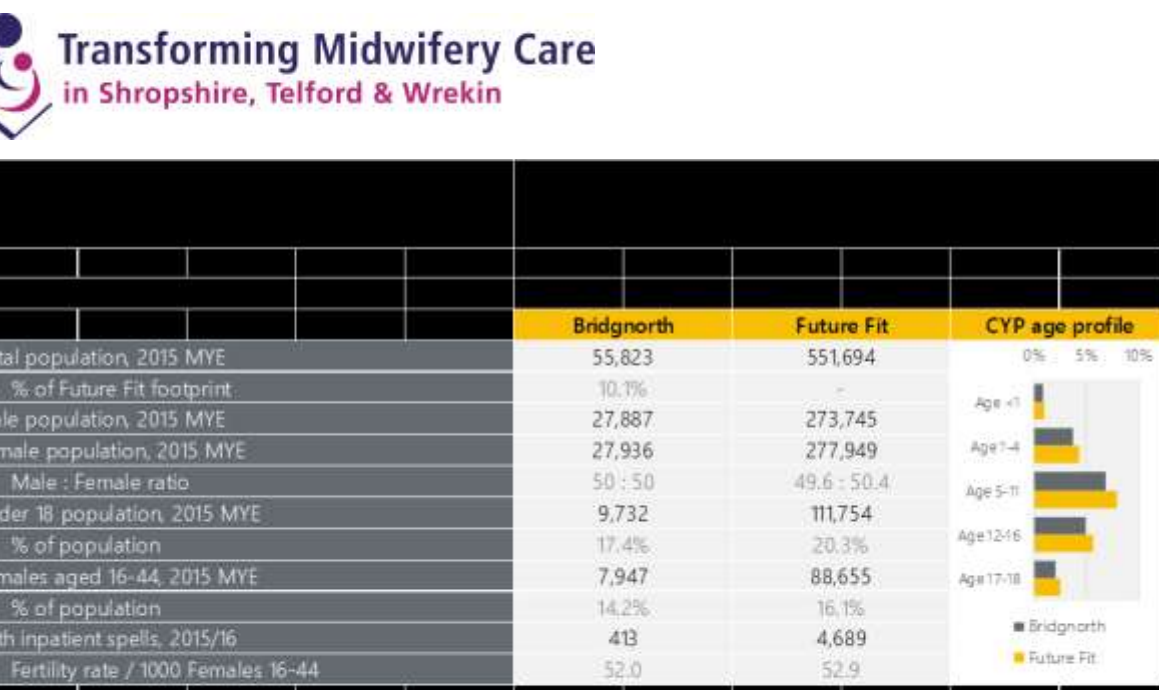
Source: SaTH activity data for maternity services 2016/17

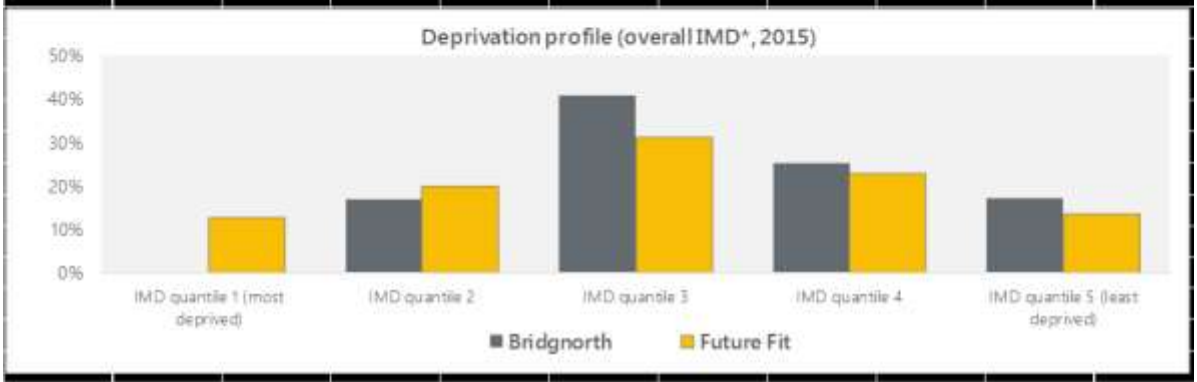
Appendix 2: Demographic profile of the different localities

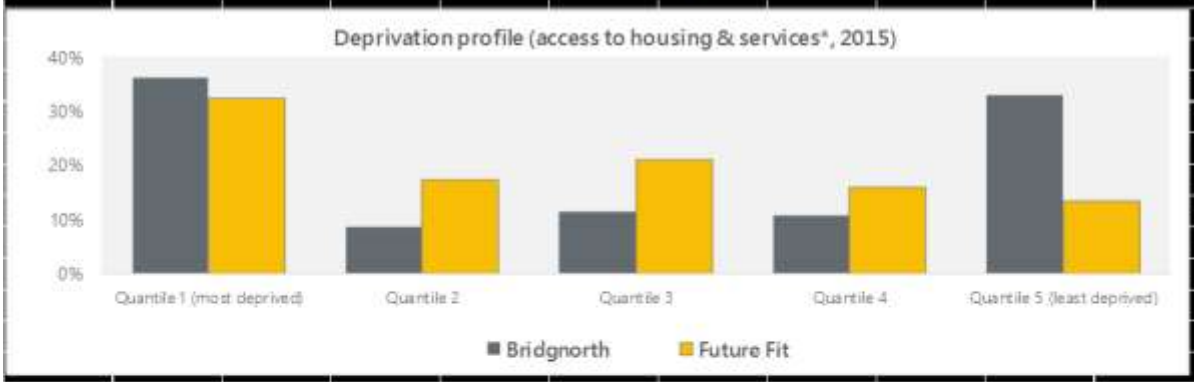
Source: Future Fit Women's and Children's Integrated Impact Assessment - https://nhsfuturefit.org/key-documents/impact-assessment/2017-4/477-appendix-15-240719-ff-iia-women-and-children-annexes-compressed-pdf/file

1) Bridgnorth
2) Hadley Castle
3) Lakeside South
4) North Shropshire
5) Oswestry
6) Shrewsbury and Atcham
7) South Shropshire
8) The Wrekin

	Bridgnorth	Future Fit	CYP age profile
Total population, 2015 MYE	55,823	551,694	
% of Future Fit footprint	10.1%	-	
Male population, 2015 MYE	27,887	273,745	
Female population, 2015 MYE	27,936	277,949	
Male : Female ratio	50 : 50	49.6 : 50.4	
Under 18 population, 2015 MYE	9,732	111,754	
% of population	17.4%	20.3%	
Females aged 16-44, 2015 MYE	7,947	88,655	
% of population	14.2%	16.1%	
Birth inpatient spells, 2015/16	413	4,689	
Fertility rate / 1000 Females 16-44	52.0	52.9	



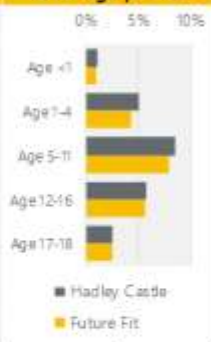


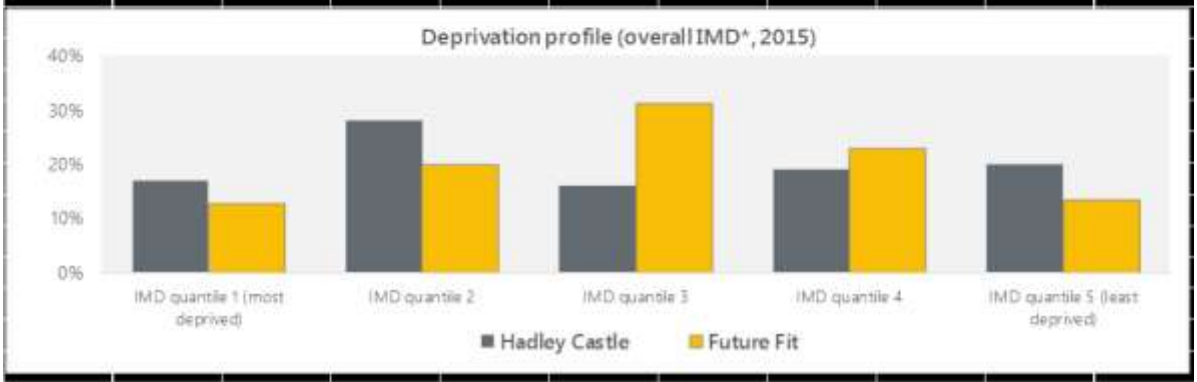


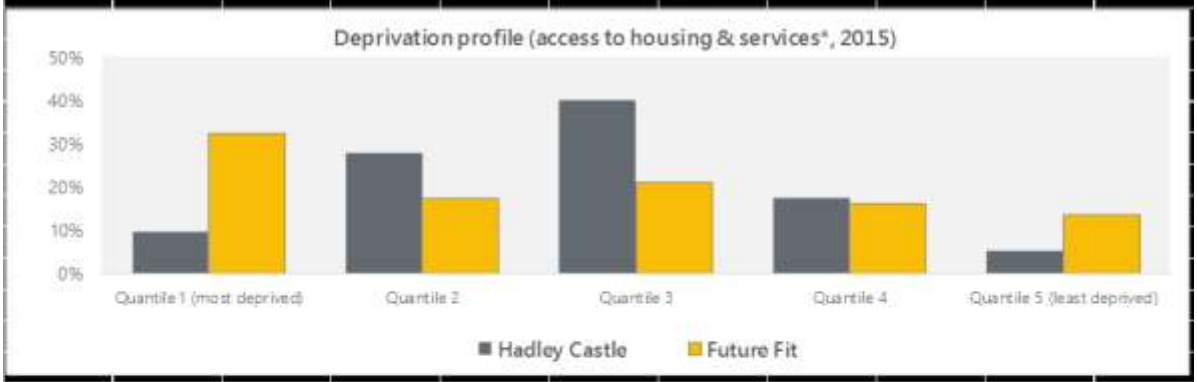
		Bridgnorth		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	9,132	19.8%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	5,185	9.3%	52,017	9.4%
Ethnic origin: White females	Census 2011	27,078	96.9%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	803	3.1%	19,195	5.1%
Religion: None (females)	Census 2011	4,766	17.1%	60,200	21.7%
Religion: Christian females	Census 2011	20,561	73.6%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	265	9.3%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	712	1.5%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	33	0.1%	329	0.1%

	Hadley Castle	Future Fit
Total population, 2015 MYE	73,366	551,694
% of Future Fit footprint	13.3%	-
Male population, 2015 MYE	36,430	273,745
Female population, 2015 MYE	36,936	277,949
Male : Female ratio	49.7 : 50.3	49.6 : 50.4
Under 18 population, 2015 MYE	16,013	111,754
% of population	21.8%	20.3%
Females aged 16-44, 2015 MYE	13,462	88,655
% of population	18.3%	16.1%
Birth inpatient spells, 2015/16	789	4,689
Fertility rate / 1000 Females 16-44	58.6	52.9

CYP age profile



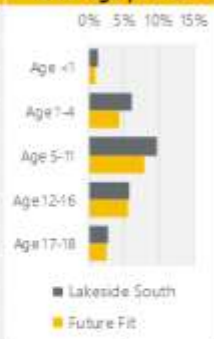


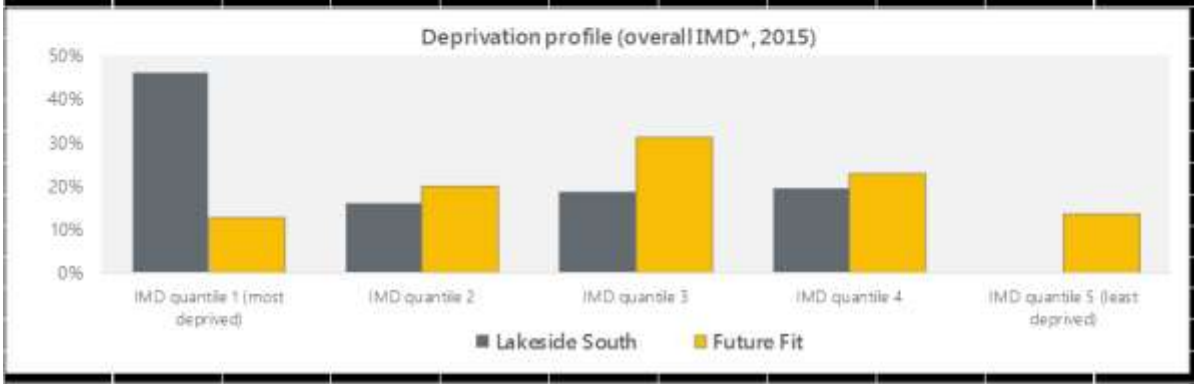


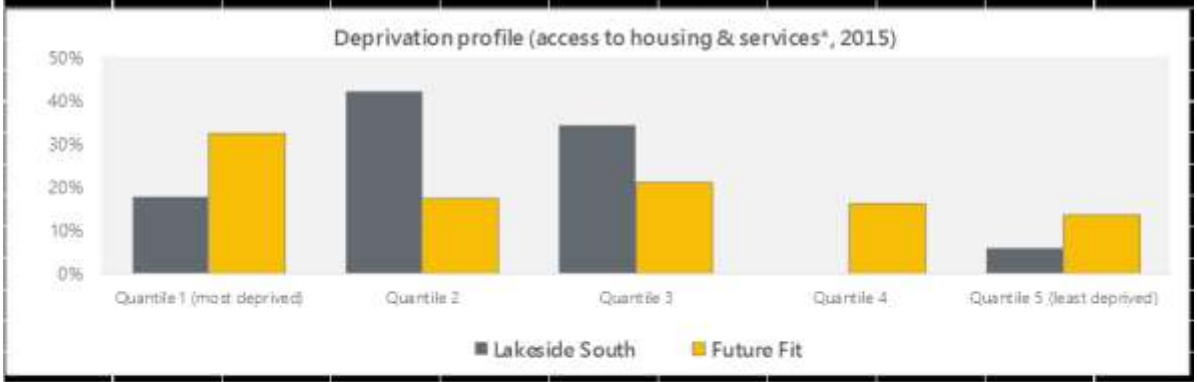
		Hadley Castle		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	10,595	18.5%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	6,856	9.3%	52,017	9.4%
Ethnic origin: White females	Census 2011	33,483	90.7%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	5,421	9.3%	19,195	5.1%
Religion: None (females)	Census 2011	7,834	21.2%	60,200	21.7%
Religion: Christian females	Census 2011	24,507	66.3%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	1,649	12.4%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	970	1.7%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	44	0.1%	329	0.1%

	Lakeside South	Future Fit
Total population, 2015 MYE	42,430	551,694
% of Future Fit footprint	7.7%	-
Male population, 2015 MYE	20,870	273,745
Female population, 2015 MYE	21,560	277,949
Male : Female ratio	49.2 : 50.8	49.6 : 50.4
Under 18 population, 2015 MYE	10,424	111,754
% of population	24.6%	20.3%
Females aged 16-44, 2015 MYE	7,952	88,655
% of population	18.7%	16.1%
Birth inpatient spells, 2015/16	578	4,689
Fertility rate / 1000 Females 16-44	72.7	52.9

CYP age profile

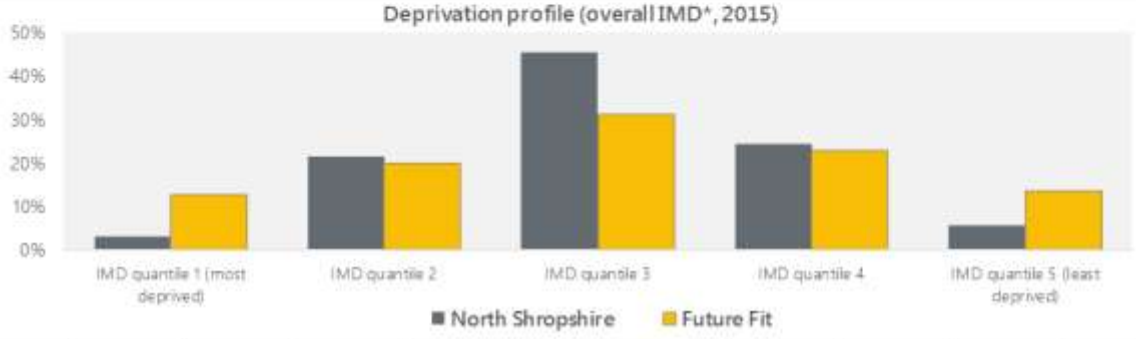






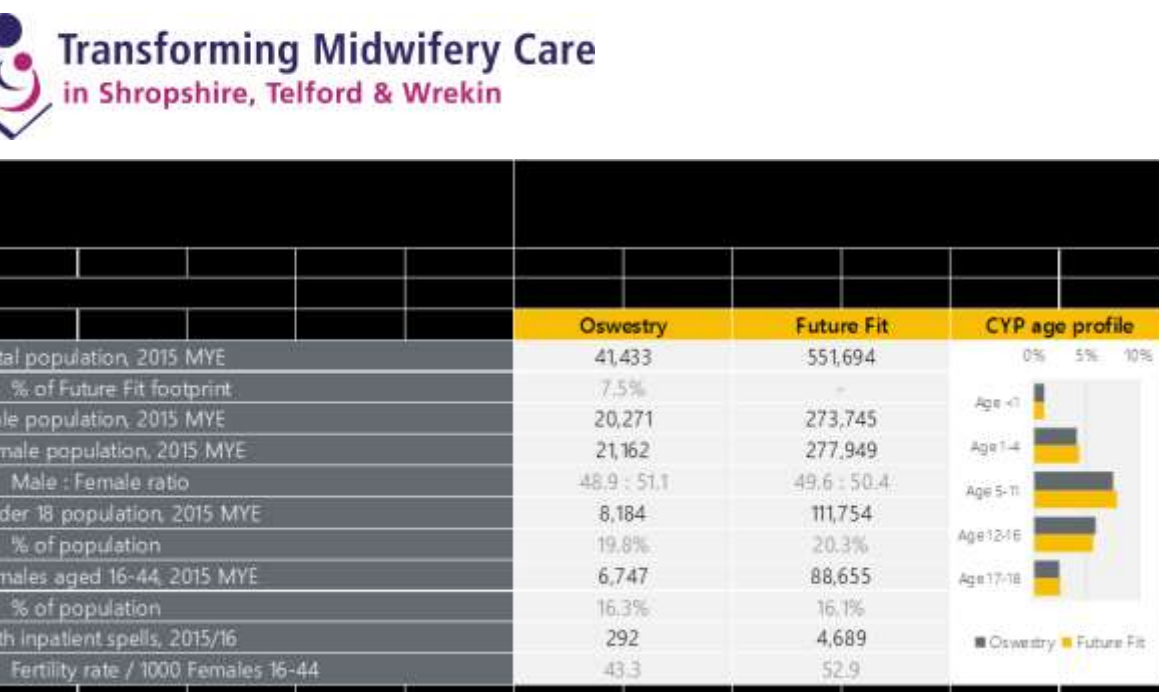
		Lakeside South		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	5,526	17.3%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	4,161	9.8%	52,017	9.4%
Ethnic origin: White females	Census 2011	19,892	92.3%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	1,771	7.7%	19,195	5.1%
Religion: None (females)	Census 2011	6,620	30.7%	60,200	21.7%
Religion: Christian females	Census 2011	12,385	57.4%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	408	11.9%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	550	1.7%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	25	0.1%	329	0.1%

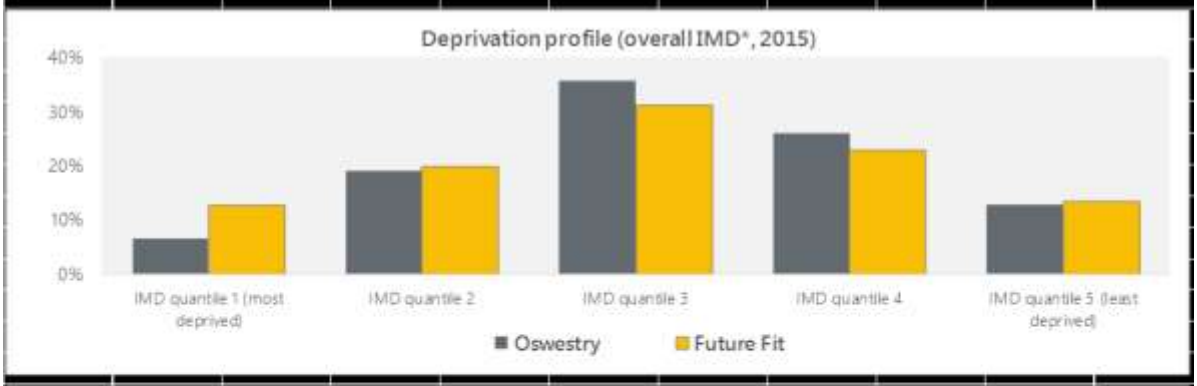
	North Shropshire	Future Fit	CYP age profile
Total population, 2015 MYE	65,705	551,694	
% of Future Fit footprint	11.9%	-	
Male population, 2015 MYE	33,206	273,745	
Female population, 2015 MYE	32,499	277,949	
Male : Female ratio	50.5 : 49.5	49.6 : 50.4	
Under 18 population, 2015 MYE	12,980	111,754	
% of population	19.8%	20.3%	
Females aged 16-44, 2015 MYE	9,858	88,655	
% of population	15.0%	16.1%	
Birth inpatient spells, 2015/16	488	4,689	
Fertility rate / 1000 Females 16-44	49.5	52.9	

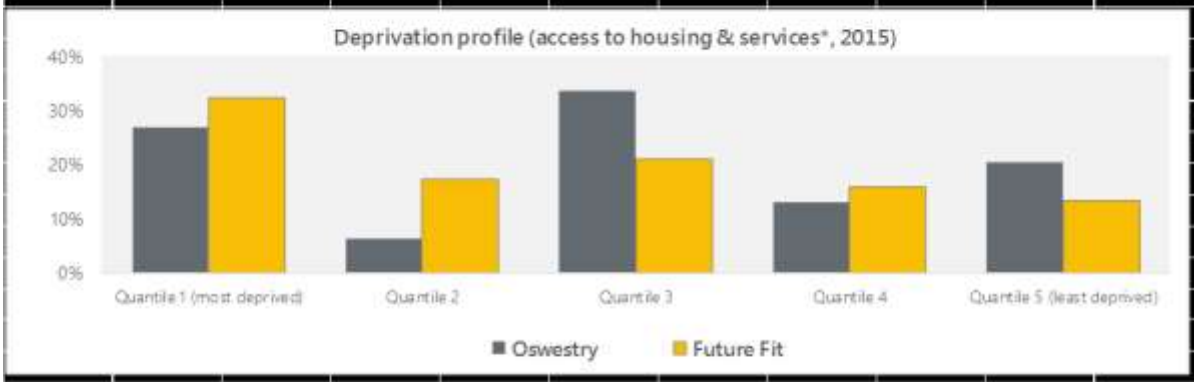


		North Shropshire		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	10,135	19.2%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	5,811	8.8%	52,017	9.4%
Ethnic origin: White females	Census 2011	31,146	95.8%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	1,082	4.2%	19,195	5.1%
Religion: None (females)	Census 2011	5,446	16.8%	60,200	21.7%
Religion: Christian females	Census 2011	23,928	73.6%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	254	9.6%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	849	1.6%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	39	0.1%	329	0.1%

	Oswestry	Future Fit	CYP age profile
Total population, 2015 MYE	41,433	551,694	
% of Future Fit footprint	7.5%	-	
Male population, 2015 MYE	20,271	273,745	
Female population, 2015 MYE	21,162	277,949	
Male : Female ratio	48.9 : 51.1	49.6 : 50.4	
Under 18 population, 2015 MYE	8,184	111,754	
% of population	19.8%	20.3%	
Females aged 16-44, 2015 MYE	6,747	88,655	
% of population	16.3%	16.1%	
Birth inpatient spells, 2015/16	292	4,689	
Fertility rate / 1000 Females 16-44	43.3	52.9	



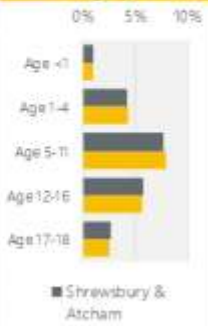


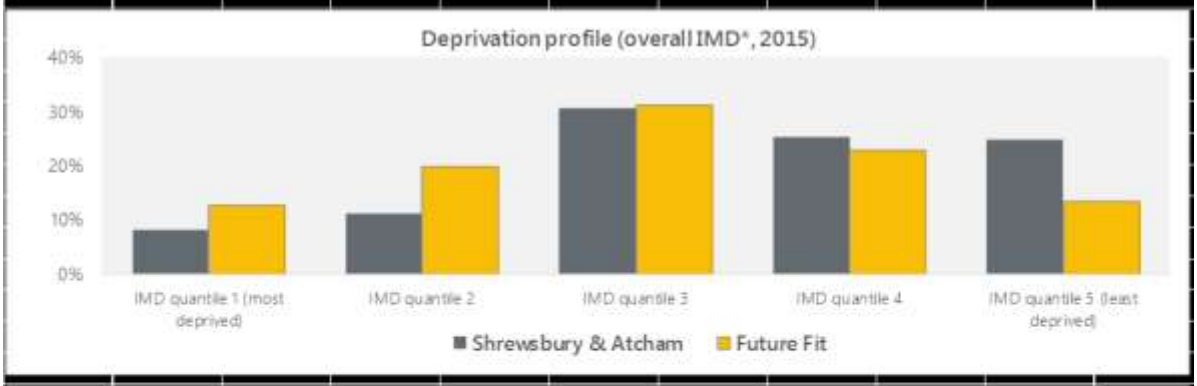


		Oswestry		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	6,171	18.6%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	3,982	9.6%	52,017	9.4%
Ethnic origin: White females	Census 2011	20,436	96.6%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	823	3.4%	19,195	5.1%
Religion: None (females)	Census 2011	4,238	20.0%	60,200	21.7%
Religion: Christian females	Census 2011	14,911	70.5%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	240	9.5%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	531	1.6%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	25	0.1%	329	0.1%

	Shrewsbury & Atcham	Future Fit
Total population, 2015 MYE	103,650	551,694
% of Future Fit footprint	18.8%	-
Male population, 2015 MYE	50,985	273,745
Female population, 2015 MYE	52,665	277,949
Male : Female ratio	49.2 : 50.8	49.6 : 50.4
Under 18 population, 2015 MYE	20,824	111,754
% of population	20.1%	20.3%
Females aged 16-44, 2015 MYE	17,045	88,655
% of population	16.4%	16.1%
Birth inpatient spells, 2015/16	1,029	4,689
Fertility rate / 1000 Females 16-44	60.4	52.9

CYP age profile

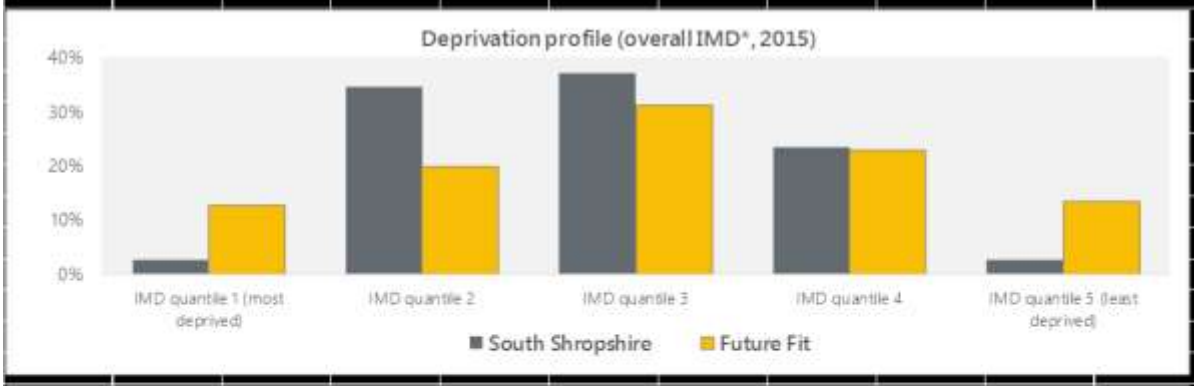




		Shrewsbury & Atcham		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	14,881	18.0%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	9,139	8.8%	52,017	9.4%
Ethnic origin: White females	Census 2011	50,406	95.7%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	2,817	4.3%	19,195	5.1%
Religion: None (females)	Census 2011	11,823	22.4%	60,200	21.7%
Religion: Christian females	Census 2011	35,609	67.6%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	705	9.9%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	1,334	1.6%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	62	0.1%	329	0.1%

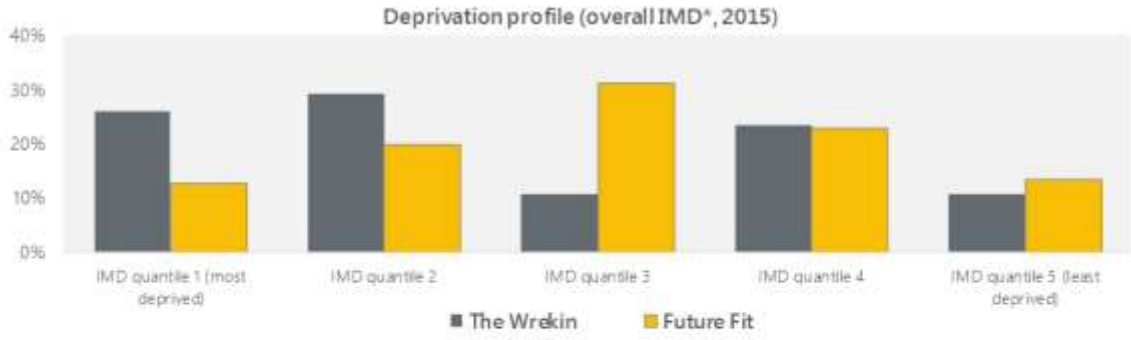
	South Shropshire	Future Fit
Total population, 2015 MYE	44,769	551,694
% of Future Fit footprint	8.1%	-
Male population, 2015 MYE	22,077	273,745
Female population, 2015 MYE	22,692	277,949
Male : Female ratio	49.3 : 50.7	49.6 : 50.4
Under 18 population, 2015 MYE	7,569	111,754
% of population	16.9%	20.3%
Females aged 16-44, 2015 MYE	5,772	88,655
% of population	12.9%	16.1%
Birth inpatient spells, 2015/16	251	4,689
Fertility rate / 1000 Females 16-44	43.5	52.9

CYP age profile



		South Shropshire		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	6,877	18.5%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	4,607	10.3%	52,017	9.4%
Ethnic origin: White females	Census 2011	22,255	98.1%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	737	1.9%	19,195	5.1%
Religion: None (females)	Census 2011	4,454	19.6%	60,200	21.7%
Religion: Christian females	Census 2011	16,146	71.2%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	309	9.2%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	559	1.5%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	27	0.1%	329	0.1%

	The Wrekin	Future Fit	CYP age profile
Total population, 2015 MYE	55,363	551,694	
% of Future Fit footprint	10.0%	-	
Male population, 2015 MYE	27,597	273,745	
Female population, 2015 MYE	27,766	277,949	
Male : Female ratio	49.8 : 50.2	49.6 : 50.4	
Under 18 population, 2015 MYE	12,694	111,754	
% of population	22.9%	20.3%	
Females aged 16-44, 2015 MYE	9,872	88,655	
% of population	17.8%	16.1%	
Birth inpatient spells, 2015/16	641	4,689	
Fertility rate / 1000 Females 16-44	64.9	52.9	



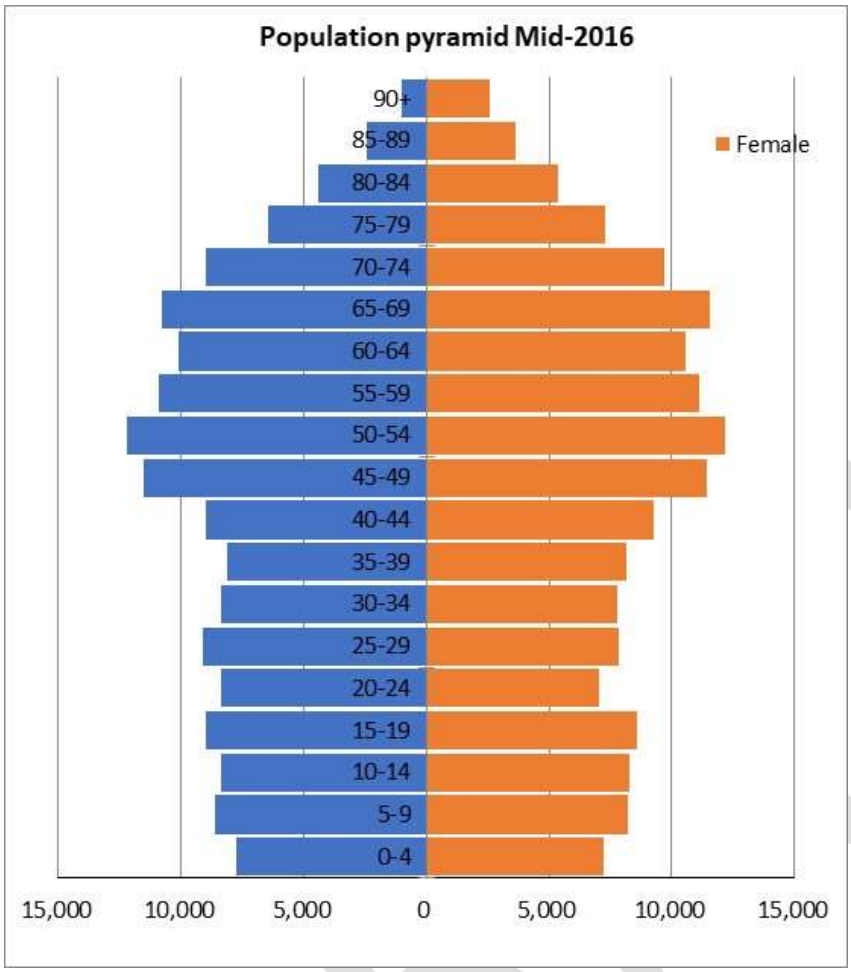
		The Wrekin		Future Fit	
Characteristic	Source / Notes	n	%	n	%
Married or civil partnership	Census 2011	8,090	19.0%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	5,085	9.2%	52,017	9.4%
Ethnic origin: White females	Census 2011	24,621	88.7%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	4,898	11.3%	19,195	5.1%
Religion: None (females)	Census 2011	6,353	22.9%	60,200	21.7%
Religion: Christian females	Census 2011	17,532	63.1%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	1,509	14.0%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	717	1.7%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GIRES (2008) & Wilson (1999)	33	0.1%	329	0.1%

Age

Protected group of Age	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
0 – 4	5.1% (15,698)	6.8% (11,344)	6.26%
5 – 9	5.1% (15,932)	6.0% (10,007)	5.61%
10 – 14	5.9% (17,915)	6.4% (10,594)	5.81%
15 – 19	6.2% (18,951)	6.9% (11,496)	6.30%
20 – 24	5.4% (16,619)	6.5% (10,863)	6.78%
25 – 29	5.1% (15,619)	6.5% (10,888)	6.89%
30 – 34	5.0% (15,504)	6.2% (10,334)	6.62%
35 – 39	5.8% (17,790)	6.7% (11,145)	6.69%
40 – 44	7.2% (22,163)	7.7% (12,850)	7.33%
45 – 49	7.7% (23,574)	7.6% (12,653)	7.32%
50 – 54	6.9% (21,004)	6.3% (10,502)	6.41%
55 – 59	6.6% (20,160)	5.9% (9,866)	5.65%
60 – 64	7.3% (22,300)	6.0% (10,010)	5.98%
65 – 69	6.2% (19,059)	4.8% (7,934)	4.73%
70 – 74	4.9% (15,153)	3.6% (5,994)	3.86%
75 – 79	3.8% (11,709)	2.7% (4,439)	3.15%
80 – 84	2.9% (8,971)	1.8% (3,042)	2.37%
85 – 89	1.8% (5,571)	1.1% (1,771)	1.46%
90 and over	0.9% (2,836)	0.5% (909)	0.76%

Source: Q5103EW NOMIS
Source Name Office for national Statistics, NOMIS table finder – official labour market statistics
Source information Source data: Census 2011, table ID QS103EW, Age by single year
Release date Latest data: 2011, last updated: 30th January 2013

Age profile: Shropshire



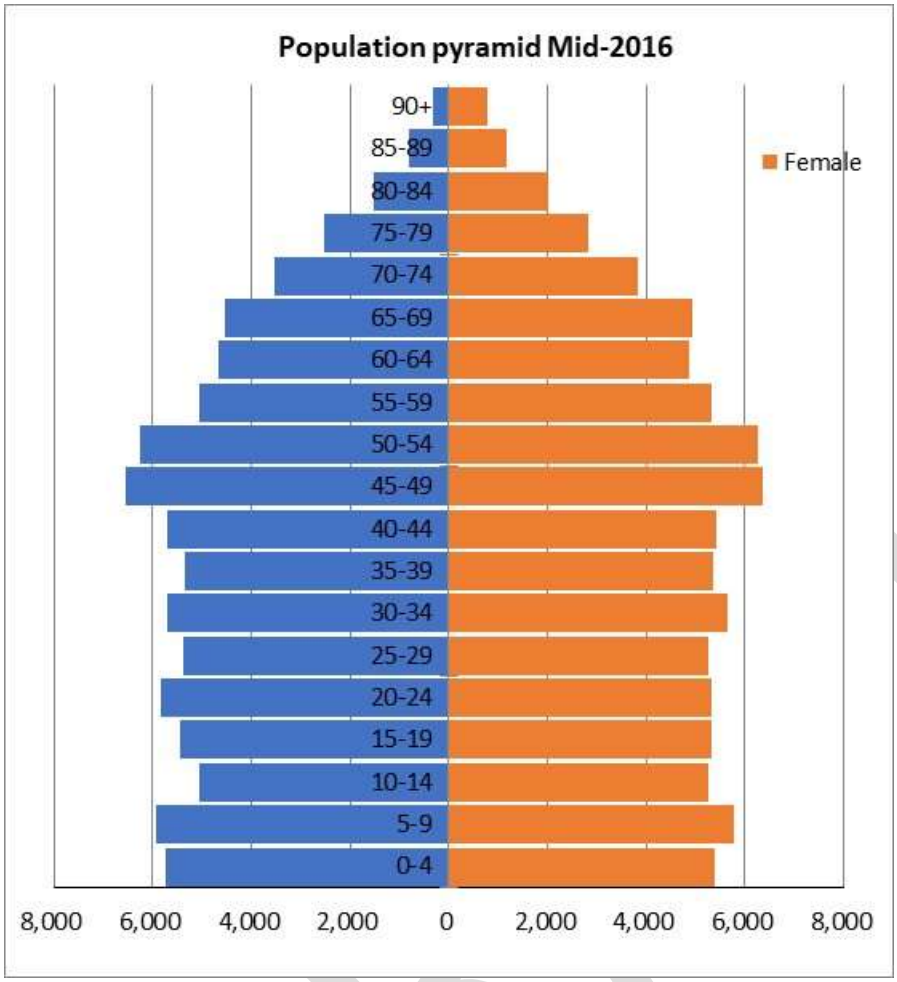
Source and further information:
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool

Source Name *Office for National Statistics*
Source information *Interactive analysis of estimated UK population change, by geography, age and sex*
Release date *22 June 2017*

Age profile by gender: Shropshire

	UK		Shropshire	
Age	Female	Male	Female	Male
0-4	5.9%	6.4%	4.6%	5.0%
5-9	5.9%	6.4%	5.2%	5.5%
10-14	5.3%	5.7%	5.3%	5.4%
15-19	5.5%	6.0%	5.4%	5.8%
20-24	6.2%	6.7%	4.5%	5.4%
25-29	6.7%	7.0%	4.9%	5.9%
30-34	6.6%	6.8%	4.9%	5.4%
35-39	6.3%	6.4%	5.2%	5.2%
40-44	6.3%	6.4%	5.9%	5.8%
45-49	7.0%	7.0%	7.2%	7.4%
50-54	7.1%	7.0%	7.7%	7.9%
55-59	6.2%	6.2%	7.1%	7.0%
60-64	5.4%	5.3%	6.7%	6.5%
65-69	5.6%	5.4%	7.3%	6.9%
70-74	4.5%	4.2%	6.2%	5.8%
75-79	3.5%	3.1%	4.6%	4.1%
80-84	2.7%	2.1%	3.4%	2.9%
85-89	1.8%	1.2%	2.3%	1.6%
90+	1.2%	0.5%	1.6%	0.7%
Total	33,270,380	32,377,674	157,832	155,541

Age profile: Telford and Wrekin



Source and further information:
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool

Source name Office for National Statistics
Source information Interactive analysis of estimated UK population change, by geography, age and sex
Release date 22 June 2017

Age profile by gender: Telford and Wrekin

	UK		Telford & Wrekin	
Age	Female	Male	Female	Male
0-4	5.9%	6.4%	6.2%	6.7%
5-9	5.9%	6.4%	6.6%	6.9%
10-14	5.3%	5.7%	6.0%	5.9%
15-19	5.5%	6.0%	6.1%	6.3%
20-24	6.2%	6.7%	6.1%	6.8%
25-29	6.7%	7.0%	6.0%	6.3%
30-34	6.6%	6.8%	6.5%	6.6%
35-39	6.3%	6.4%	6.1%	6.2%
40-44	6.3%	6.4%	6.2%	6.6%
45-49	7.0%	7.0%	7.3%	7.6%
50-54	7.1%	7.0%	7.2%	7.3%
55-59	6.2%	6.2%	6.1%	5.9%
60-64	5.4%	5.3%	5.6%	5.4%
65-69	5.6%	5.4%	5.7%	5.3%
70-74	4.5%	4.2%	4.4%	4.1%
75-79	3.5%	3.1%	3.2%	3.0%
80-84	2.7%	2.1%	2.3%	1.8%
85-89	1.8%	1.2%	1.3%	0.9%
90+	1.2%	0.5%	0.9%	0.4%
Total	33,270,380	32,377,674	87,074	85,902

Source and further information:
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool

Source name Office for National Statistics
Source information Interactive analysis of estimated UK population change, by geography, age and sex
Release date 22 June 2017

Projected Population Change by Broad Age Groups

Shropshire

Each of the broad population groups shown below represents a key life stage; Early Years (0-4 years); School Age (5-15 years); Working Age (16-64 years); Retirement Age (65-84 years) and Elderly (85 years and over). Individually, each of these population groups has specific needs which impact directly on the demand for public services. The table below expresses projected population change (2016-2041) by broad age group, as a proportion of the total population of Shropshire.

Source: Shropshire Council Summary Analysis – 2016 Sub-national Population Projections to 2041 for Shropshire (released by the Office for National Statistics (ONS) –24th May 2018

https://shropshire.gov.uk/information-intelligence-and-insight/facts-and-figures/population/future-projections/

Telford and Wrekin

	0-15	16-24	25-44	45-64	64-84	85+	All ages	Population change 2016-2031
Lakeside South	9,900	5,800	11,800	10,600	8,400	1,700	48,100	5,700
Hadley Castle	18,300	9,200	21,100	18,900	14,600	3,100	85,000	10,100
The Wrekin	12,100	7,000	16,100	14,900	11,400	2,200	63,700	7,500
Telford and Wrekin	**40,300**	**21,900**	**49,000**	**44,400**	**34,400**	**6,900**	**196,900**	**23,300**

Projections are only available for Telford and Wrekin as a whole, so these figures have been proportionally applied to localities based on 2015 population estimates. Counts have been independently rounded to the nearest 100.

Source: Objectively Assessed Need Report, Appendix B – Demographic Projections for Telford & Wrekin. Allocated to localities based on Office for National Statistics 2015 Output Area population Mid-Year Estimates
Note: We have been unable to obtain more up-to-date data.

Disability

Disability	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
Long term condition / disability where day to day activities are limited a lot	8.4% (25,568)	9.0% (15,060)	8.3%
Long term condition / disability where day to day activities are limited a little	10.2% (31,258)	9.6% (15,935)	9.3%

Source: NOMIS

Marriage and civil partnership

Marital status	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
Married	48.3% (144,005)	45.9% (75,505)	46.6%
Same sex civil partnership	0.1% (319)	0.1% (217)	0.2 %

Source: Office for National Statistics (27 March 2011.) This table provides information that classifies residents aged 16 and over by marital and civil partnership status.

Race

Ethnic background	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %		
White British	95.4% (292,047)	89.5% (149,096)	79.8%		
White Irish	0.5% (1,410)	0.4% (729)	1.0%		
White: Gypsy or Irish Traveller	0.1% (312)	0.1% (166)	0.1%		
White: Other	2.0%	2.7%	1.8% (1,246)	2.1%	4.6%

	(6,105)	(4,424)		(11,775)	
Mixed/Multiple Ethnic Groups: White and Black Caribbean	0.2% (765)	0.9% (1,423)	0.2% (107)	0.4% (2,295)	0.8%
Mixed/Multiple Ethnic Groups: White and Black African	0.1% (231)	0.2% (278)	0.1% (44)	0.1% (553)	0.3%
Mixed/Multiple Ethnic Groups: White and Asian	0.2% (669)	0.5% (799)	0.2% (144)	0.2% (1,612)	0.6%
Mixed/Multiple Ethnic Groups: Other Mixed	0.2% (503)	0.3% (483)	0.1% (86)	0.1% (1,072)	0.5%
Asian/Asian British: Indian	0.2% (752)	1.8% (3,076)	0.1% (59)	0.7% (3,887)	2.6%
Asian/Asian British: Pakistani	0.1% (216)	1.3% (2,243)	0.0% (3)	0.4% (2,462)	2.1%
Asian/Asian British: Bangladeshi	0.1% (208)	0.1% (162)	0.1% (41)	0.1% (411)	0.8%
Asian/Asian British: Chinese	0.3% (1,020)	0.4% (647)	0.1% (56)	0.3% (1,723)	0.7%
Asian/Asian British: Other Asian	0.3% (893)	0.5% (863)	0.2% (138)	0.3% (1,894)	1.5%
Black/African/Caribbean/Black British: African	0.1% (302)	0.5% (863)	0.0% (21)	0.2% (1,346)	1.8%
Black/African/Caribbean/Black British: Caribbean	0.1% (164)	0.4% (607)	0.0% (33)	0.1% (804)	1.1%
Black/African/Caribbean/Black British: Other Black	0.0% (114)	0.1% (149)	0.0% (9)	0.1% (272)	0.5%
Other Ethnic Group: Arab	0.1% (179)	0.1% (86)	0.0% (12)	0.1% (277)	0.4%
Other Ethnic Group: Any Other Ethnic Group	0.1% (239)	0.2% (387)	0.1% (40)	0.1% (666)	0.6%

Source: KS201EW NOMIS Official for National Statistics, 27 March 2011

Religion

Religion	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
Christian	68.7% (210,268)	61.7% (102,892)	59.4%
Buddhist	0.3% (792)	0.2% (398)	0.5%
Hindu	0.1% (378)	0.5% (872)	1.5%
Jewish	0.04% (127)	0.04 (78)	0.5%
Muslim	0.3% (989)	1.8% (3,019)	5.0%
Sikh	0.1% (256)	1.3% (2,118)	0.8%
Other religion	0.4% (1,113)	0.4% (692)	0.4%
No religion	22.8% (69,725)	27.4% (45,599)	24.7%
Religion not stated	7.3% (22,481)	6.6% (10,973)	7.2%

Source: KS209EW NOMIS Office for National Statistics 27 March 2011

Sex

Protected group: Sex	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
Total	**306,129**	**166,641**	**100%**
Male population	49.5% (151,606)	49.5% (82,549)	49.2%
Female population	50.5% (154,523)	50.5% (84,092)	50.8%

Source: Office of National Statistics 4 October 2017 Sexual identity in the UK from 2012 to 2016 by region, sex, age, marital status, ethnicity and National Statistics Socio-economic Classification.

Deprivation

Deprivation	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
Economically active – unemployment rate	3.6% Oct 2016 - Sept 2017	4.6% Oct 2016 - Sept 2017	4.3% Nov 2017 - Jan 2018
Deprivation score	16.69	24.85	19.57

Source of the unemployment data was from NOMIS. https://www.nomisweb.co.uk
Telford/England: https://www.nomisweb.co.uk/reports/lmp/la/1946157172/report.aspx?town=telford#tabeinact
Shropshire: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabeinact
Source of deprivation scores was cited in each of the fingertip PHE reports: http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000051.pdf

Appendix 3: Equality legislation

The Equality Act 2010

The Equality Act 2010 protects people against discrimination, harassment and victimisation in relation to housing, education, clubs, the provision of services and work. It unifies and extends previous equality legislation.

The groups the Act specifically covers are called 'protected characteristics'. These are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership (with some restrictions as protection doesn't apply to service provision)
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation.

Information on protected characteristics

Age: This refers to a person belonging to a particular age (e.g. 50-year-old) or range of ages (e.g. 18 to 30 year old). Age includes treating someone less favourably for reasons relating to their age (whether young or old).

Disability: A person has a disability if s/he has a physical, mental impairment, Learning Disability or sensory impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Disability includes sensory impairments such as sight and hearing. Also includes mental impairments such as Asperger's syndrome, autism, dyslexia and mental illness. Within the act there is no requirement that the mental illness has to be clinically recognised. The focus of the act is the impairment rather than the cause.

Certain medical conditions are protected under disability. These include Cancer, HIV and Multiple Sclerosis.

People with genetic conditions, would be protected under disability if the effect of the condition has a substantial and long term adverse effect.

People with a past disability which falls into the definition remain protected.

Gender Reassignment: This refers to a person proposing to undergo, is undergoing (or part of process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. The term of transgender falls under this protected group.

Marriage and Civil Partnership: Protection is for people that are legally married or in a legal civil partnership. It only recognises people in formally recognised unions and therefore does not include people that are not married, cohabiting couples, widows, divorcees and fiancées. Protection of this group does not extend to service provision.

Pregnancy and Maternity: The Act protects women that are discriminated due to their pregnancy or maternity – which includes breastfeeding. This protection may relate to current or previous pregnancy. Protection extends after the birth after 26 weeks from the date of the birth.

Protection includes women where baby was still born in cases where she was pregnant for at least 24 weeks prior to birth.

Race: Race includes colour, nationality, and or ethnic or national origins. Nationality is determined by citizenship.

Religion and belief: The Equality Act does not define religion or belief explicitly. It includes the main world religions such as Christianity, Islam, Judaism, Hinduism, Sikhism, Humanism, Secularism and Paganism. The act protects any religion, religious or philosophical belief and a lack of religion / belief.

Sex: A man or a woman, but also includes men and women as groups. Treating a man or woman or men and women less favourably for reasons relating to their sex. People describing themselves as non-binary are not currently recognised within the act.

Sexual Orientation: A person's sexual attraction towards their own sex, the opposite sex or more than one sex. This includes people who are Lesbian, Gay, Bisexual or Heterosexual.

Public Sector Equality Duty (2011)

PSED section 149 of the Equality Act 2010 states in the exercise of their functions must have due regard to the duty to:

- eliminate unlawful discrimination, harassment, victimisation and other prohibited conduct
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those that do not.

The Health and Social Care Act (2012) 14T Duties as to reducing inequalities

Each clinical commissioning group, must in the exercise of its functions, have due regard to the need to:

- reduce inequalities between patients with respect to their ability to access health services
- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

These principles have been taken from the Equality and Human Rights Commission's paper on making fair financial decisions (Equality and Human Rights Commission, 2012).

Case law sets out broad principles about what public authorities need to do to have due regard to the aims set out in the general equality duties. These are sometimes referred to as the 'Brown principles' and set out how courts interpret the duties. They are not additional legal requirements, but form part of the Public Sector Equality Duty as contained in section 149 of the Equality Act 2010. Under the duty local authorities must, in the exercise of their functions have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

In summary, the Brown principles say that:

- Decision-makers must be made aware of their duty to have 'due regard' and to the aims of the duty.
- Due regard is fulfilled before and at the time a particular policy that will or might affect people with protected characteristics is under consideration, as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind. A body subject to the duty cannot satisfy the duty by justifying a decision after it has been taken. Attempts to justify a decision as being consistent with the exercise of the duty, when it was not considered before the decision, are not enough to discharge the duty. General regard to the issue of equality is not enough to comply with the duty.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty has to be integrated within the discharge of the public functions of the body subject to the duty. It is not a question of 'ticking boxes'.
- The duty cannot be delegated and will always remain on the body subject to it.

It is good practice for those exercising public functions to keep an accurate record showing that they had actually considered the general equality duty and pondered relevant questions. If records are not kept it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed by the equality duties.

Sources: Equality and Human Rights Commission (2012). Making Fair Financial Decisions: An Assessment of HM Treasury's 2010 Spending Review conducted under Section 31 of the 2006 Equality Act. Manchester: Equality and Human Rights Commission.

HOSC paper

1. Introduction.

Following our presentation at the Joint Health Overview Scrutiny Committee in January 2019 we were asked to return to the committee in the future to advise of the outcome of further patients and public engagement into proposed Ophthalmology reconfiguration of services provided within Shrewsbury and Telford Hospitals NHS Trust.

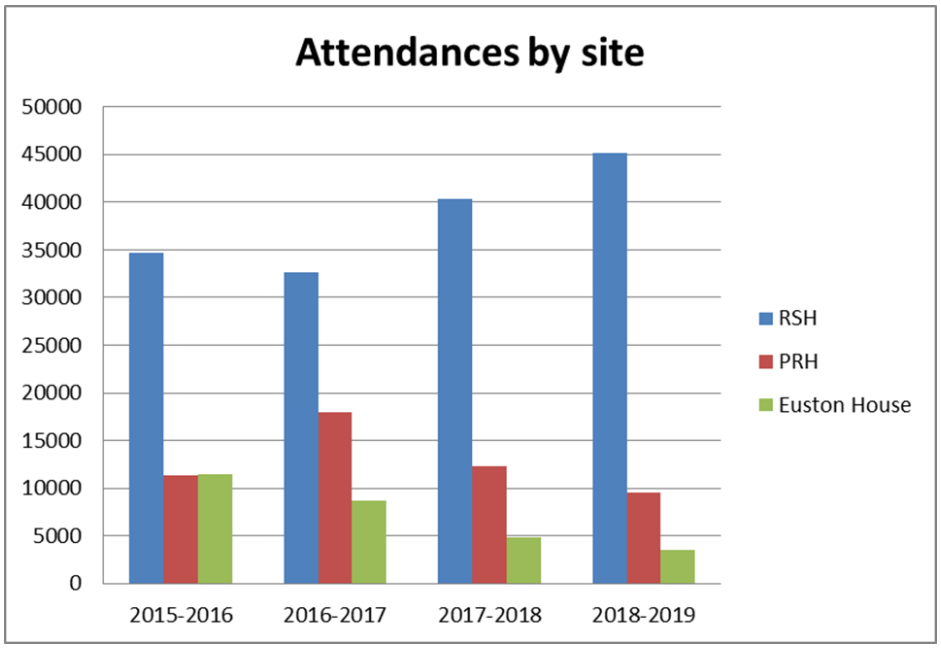
2. Background.

Ophthalmology has various challenges which have prevented the department from delivering a sustainable service. In October 2016 NHS England chaired a Risk Review Meeting which was attended by members of the Trust Executive team, NHSI, the CQC and both CCG's. The Trust and CCG's presented the challenges within the Ophthalmology service and made recommendations as to how these challenges could be addressed. One of these commitments was to reconfigure Ophthalmology accommodation. This is also in line with the support the service received from the Board when it presented its Deep Dive 2015.

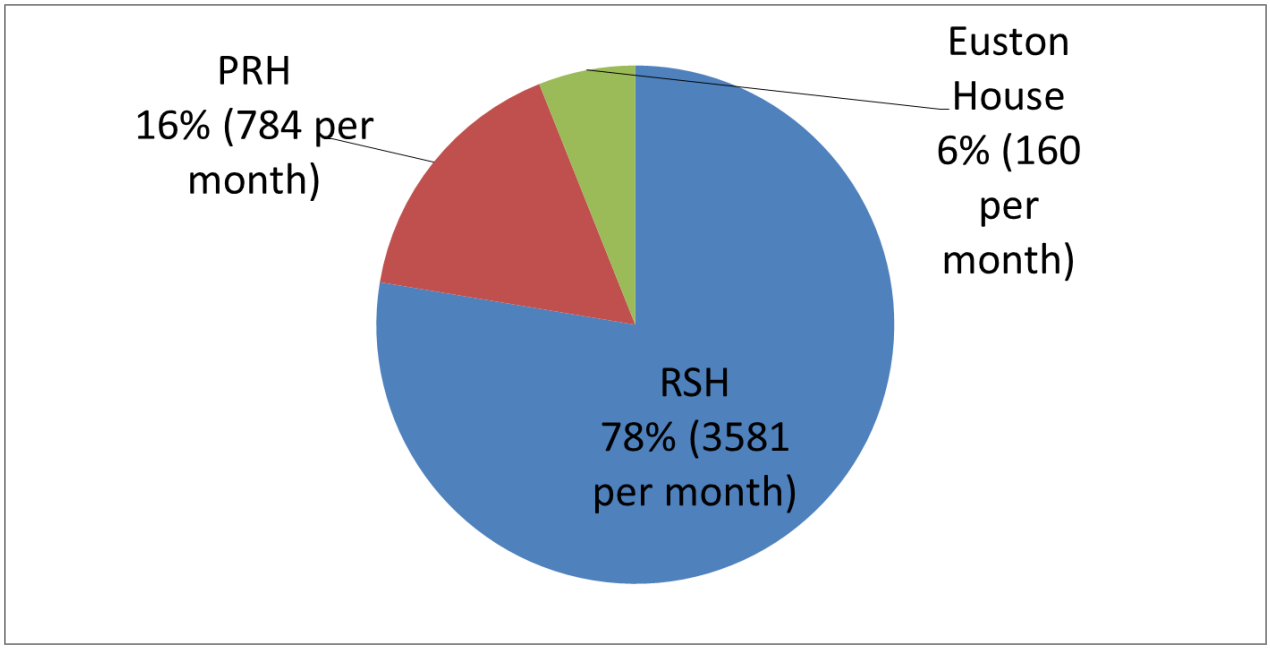
As a result SaTH approved £800k of investment to improve outpatient services at RSH and the department successfully relocated into improved premises in June 2017 and after further investment paediatric ophthalmology outpatients moved to new location in October 2017.

At the time of approval, it was highlighted that there would need to be consideration for Ophthalmology to be delivered from 2 sites instead of 3 by relocating services provided at Euston House (Telford) to Copthorne RSH and PRH.

3. Analysis of activity



Monthly Outpatient Attendances



4. Engagement.

An Engagement Plan was developed by SaTH and methodology within supported by the Clinical Commissioning Groups, Patients Groups and Representatives, as well as HOSC in January. This engagement plan built on the numerous stakeholder engagement sessions that brought interested parties and patient representative groups together in order to shape proposals for consideration. During January and February 2019 a survey was carried out seeking the views of our local communities on the following two options:

- Option 1: No change.
- Option 2: To relocate adult outpatient services from ICAT back to the respective main hospital sites and relocate cataract surgery from ICAT to Copthorne building.

The survey was successfully carried out and was sent to 162 community and voluntary sector organisations with a request to distribute further, was provided on SaTHs website, promoted through social media. Paper copies were distributed within the 3 hospital sites along with pop up stands. Staff briefed and supported patients to complete the surveys where assistance was required.

There were 267 responses to the survey. 61% were from patients who had been seen at one of our clinics that day.

Respondents demographics were:

Telford and Wrekin	48.63%
Shropshire	43.53%
Mid-Wales	7.45%
Out of area	0.39%

Key findings:

- 85% of patients would prefer to have one longer appointment rather than several shorter ones.
- 80% of patients travelled to appointments by car or by non emergency patient transport. The remainder used public transport (11%), walked (3%), taxi (2%), volunteer drivers (1%), 0.5% cycling and 2.5% didn't specify.
- 115 comments were received with the main themes:
    - Transport and travel times- difficulties using public transport from rural areas, car parking charges and lack of parking
    - Service experience- 65% positive, 27% less favourable experiences some of these related to historic and some related to other service providers
    - Staffing- 80% of comments were positive describing staff as "very friendly and most helpful". Respondents commented that the service could be improved by seeing the same consultant for continuity of care.

The results of the survey were shared at a stakeholder event held on the 25th June 2019. Representatives were invited and attended from Telford and Wrekin and Shropshire CCGs, Healthwatch, RNIB, Macular Society, Volunteer Organisations, patients and SaTH. Unfortunately members of the Welsh HB were invited however were not in attendance. The Group were asked to consider what benefits and disadvantages of the proposed plans and were asked to consider what their ongoing concerns were and what could be done better?

The overwhelming feedback echoed the responses from the survey e.g challenges with travelling, preferring one longer appointment and wanting a sustainable service for patients in the local community. Having all services at the same site was more important than any travel issues that might arise however representatives recognised that for some patients this would be challenging.

4. Conclusion

HOSC are asked to consider the outcome of the engagement and offer feedback for the Trust to consider whether to proceed with relocate adult outpatient services from Euston House to the respective main hospital sites and relocate cataract surgery from Euston House to RSH.

The views of HOSC will be incorporated within the papers to Trust Board.

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The Shrewsbury and Telford Hospital NHS Trust

ENGAGEMENT PLAN

PROPOSED RECONFIGURATION OF OPHTHALMOLOGY SERVICES

1 INTRODUCTION

This is an engagement plan to support The Shrewsbury and Telford Hospital NHS Trust to seek the views of Eye Department services users, interested parties and staff on the proposed reconfiguration of ophthalmology services.

This plan will outline the engagement and communication events that have happened to date and outline the next steps.

The engagement period will run for 6 weeks and during that time will seek the views of Eye Department service users from the current sites through a programme of targeted engagement, which include a stakeholder event in order to seek views from representative groups such as HealthWatch, Commissioners, Macular Society, Royal National Institute for the Blind etc.

The results of the engagement period will be analysed and presented to the Trust Board alongside associated recommendations in a public Board meeting in April 2019

2 CONTEXT AND OVERVIEW

For many years Ophthalmology Hospital Eye Services provided at Shrewsbury and Telford Hospital NHS Trust have been considered as a “fragile” service and has had many challenges.

The Ophthalmology department has had service reviews and recommendations from the Royal College of Ophthalmology, Macular Society, Healthwatch and others who all identified shortfalls and recommended that improvements were required. In addition to these reviews, Health Education West Midlands (HEWM) reviewed the service in July 2017. HEWM are responsible for the training and education of junior doctors. The visit was arranged following concerns that deanery trainees highlighted the lack of cataract surgery training opportunities as a major concern.

The Trust and Commissioners also recognised these shortfalls and a Risk Review meeting chaired by NHS England took place in October 2016. At the meeting the Trust presented its review of the service and the areas which needed addressing to ensure the provision of a safe and sustainable service for the long term in the County and Mid Wales.

One of the areas outlined for improvement was the Substandard and Fragmented Accommodation. The department strives to provide a high quality, safe service to patients and recognises that the patient accommodation forms an essential part.

3 HISTORICAL ACCOMMODATION OVERVIEW

Ophthalmology provides services from 3 sites; RSH, PRH and Euston House in Telford, as well as from peripheral units throughout the locality. The increasing demands on the service means that the Ophthalmology department accommodation is not fit for purpose. This view is supported by the afore mentioned external bodies, who deemed that the facilities at RSH clinic 10 were no longer suitable for Ophthalmology patients.

As a result the Trust supported a capital investment to redevelop space within the Copthorne building on the RSH site to build an ophthalmology patient friendly facility to relocate Clinic 10. The new facility opened to adult patients on the 26th June 2017 and to paediatric patients in October 2017.

These new facilities provide excellent provision of outpatient services for patients with sight conditions. The new facility and service as a whole was inspected by Healthwatch in November 2017 as well as the Getting It right First Time (GIRFT) assessment in August 2017. Both reports recognised the improvements the department has made but also indicated that further improvements need to be made.

4 CURRENT ACCOMMODATION OVERVIEW

Ophthalmology currently provides services from 3 sites; RSH, PRH and Euston House in Telford, as well as from peripheral units throughout the locality.

Site	Outpatients	Surgery
RSH	**Adult** & **Paediatric** All sub-specialisms and Urgent Eye Clinic	**Adult** General Anaesthetic and Local Anaesthetic sub-specialisms, complex and “simple”. Emergency Operating.
PRH	**Adult** & **Paediatric** All sub-specialisms **Excluding** the following: Urgent Eye Clinic Injections for Medical Retina related conditions Cornea Cataract assessment	**Paediatric** General Anaesthetic and Local Anaesthetic **Adult** Oculoplasty surgery.
ICAT	**Adult** The following services only: Cataract assessments, non-specialised ophthalmology and the ability to deliver lasers. .	**Adult** The following services only: Local Anaesthetic “simple” Cataract and Injections

Activity at each site is summarised in the below two tables and is split by Adults and Paediatrics:

Adults

Financial Year	RSH		PRH		Euston House	
	Outpatients	Surgery	Outpatients	Surgery	Outpatients	Surgery
2015-2016	29115	1884	6208	64	10114	1323
2016-2017	27486	1657	12920	58	7516	1134
2017-2018	34891	2693**	6488	58	3901	924
2018-2019*	37332	2110	4529	38	2602	1694

*2018-2019 is predicted full year effect based on activity levels April-August 2018.
** in 2017-2018 SaTH commissioned Nuffield Health to provide 115 surgical cases which are included within the RSH figures.

Paediatrics

Financial Year	RSH		PRH		Euston House	
	Outpatients	Surgery	Outpatients	Surgery	Outpatients	Surgery
2015-2016	3726	10	4973	149	13	0
2016-2017	3434	3	4864	66	17	0
2017-2018	2734	1	5748	54	3	0
2018-2019*	4781	7	4303	91	2	0

*2018-2019 is predicted full year effect based on activity levels April-August 2018.

5 CONCERNS WITH CURRENT SITE CONFIGURATION

The Trust outlined its challenges within the risk review meeting in October 2016, stakeholder engagement sessions and the Trust Board April 2017. A summary of the challenges identified were as follows:

- Substandard and fragmented accommodation;
- On-going serious untoward incidents;
- Workforce gaps and Team dynamics
- The inability to see patients within the past maximum wait standard, and demand exceeding capacity.

All 4 challenges are interlinked and in particular substandard and fragmented accommodation affects the others in the following ways:

***Workforce Gaps*:** The department has had some significant challenges in recruitment and retention of medical staff for a number of years. This has resulted in the department employing agency clinicians who put an additional strain on finances and whilst bolstering the quantity of staff the commitment to improving the department may not be their priority. Following the investment into accommodation at RSH SaTH has managed to recruit to most vacancies with NHS locum contracts

and reduced its reliance on agency staff. Investing in an improved environment with reduced travelling requirements would encourage persons currently in post to remain and improve the chances of employment into vacancies. Reducing the number of sites would allow travel time to be put back into clinical activity.

The department has also been subject to sickness absences, whilst we recognise that this is unpredictable having more staff at a reduced number of sites would potentially mean appointments would not need to be cancelled due to sickness.

The Trust supports junior doctor training and has 5 junior doctors who are in training allocated to the Trust. Health Education West Midlands who manage the trainees have advised that we risk losing our right to be trainers if we cannot provide sufficient access and training opportunities with theatres specifically Cataract operating. At Euston House we are unable to train juniors within the theatre set up due to lack of adequate space.

Workforce remains the departments biggest risk and remains fragile.

***Team dynamics*:** Having clinicians spread too thinly across sites affects the ability to work as a team and this also impacts on patients who need to be seen by more than one professional. Having staff working alongside each other enables many patients to have all of their eye needs considered in one appointment rather than multiple trips.

Inability to see patients within the Past Maximum Waiting time standard, and demand exceeding capacity: Across the whole ophthalmology service demand is outstripping capacity.

The long waiting times in Ophthalmology can be categorised into two main areas; patients on a referral to treatment (RTT) pathway awaiting first outpatient appointment and those waiting for follow up appointments (PMW).

<u>RTT- referral to treatment time</u>

RTT performance within Ophthalmology has achieved since January 2018 having failed for the previous 3 quarters. Performance against RTT is affected by available capacity and new referral demand. The workforce issues identified within the “Workforce Gaps and Team dynamics” sections impact on the capacity to deliver RTT performance. The department actively flexes available capacity to meet the urgent clinical demand which means routine conditions may wait longer. RTT performance has mainly been affected by increases in demand specifically and significantly for referrals for consideration for cataract surgery. Productivity at Euston House within the cataract theatre is limited due to the design of the unit. Activity suggests that 6 patients are treated per list. Moving activity to a new purpose built theatre would increase productivity in line with clinical guidelines and in line with GIRFT review recommendations of 8 patients per list.

<u>PMW- Past Maximum Waiting Time for follow up appointment</u>

There was a significant issue within Ophthalmology with a large number of patients waiting longer than clinically recommended for follow up appointments. In January 2016 there were just under 3300 patients waiting longer than they should. This issue has been on-going for a number of years

and since January 2016 these numbers have significantly reduced and at 3rd August 2018 it was 689 patients with the lowest recorded at 252 on 27th October 2017.
Following the risk review meeting in October 2016 one of the interventions the commissioners and SaTH jointly agreed to suspend new referrals for general, glaucoma and adult squint surgery. This closure was implemented to reduce the PMW numbers. Following the improvements within the accommodation and workforce the Trust and Commissioners agreed to reopen SaTH service to new referrals for General and Glaucoma from the 1st April and following a period of clinician training Adult Squint Surgery is planned to commence in 2019-20.

Ongoing Serious Untoward incidents

The department had a number of serious incidents over a number of years which related to two themes:

- Individual clinicial issues and poor practice.
- Incidents relating to patients waiting longer than clinically recommended

The department recognised this and realigned its governance structures and as part of this Mr Sagili (Consultant Ophthalmologist) was appointed as the departments Consultant Governance Lead. Harm pro-formas completed by the clinicians for patients that has waited longer than clinically determined and concerns are investigated at the patient safety meeting. Monthly department patient safety meetings take place to review incidents. Relevant trends and outcomes of investigations carried out by the patient safety representatives are reported at the monthly Governence meeting to aid learning and to support the delivery of the action plans. Any serious incidents and those causing harm are investigated in line with Trust policies and procedures.

To specifically address the 2 themes identified above:

- “Individual clinicial issues and poor practice” the department has been supported by the Trust in taking action around the individuals that undertook poor clinical practice which has meant that members of staff no longer work for the Trust and others have been supported with retraining.
- “incidents relating to patients waiting longer than clinically recommended” as waiting times remain an concern it presents a risk.

6 ENGAGEMENT OVERVIEW (TO DATE)

The Trust and Department recognise the importance of service user engagement and involvement with patients in considering changes in service provision. Since the October 2016 risk review meeting the Trust has completed two stakeholder engagement sessions the first was held on Tuesday 21st March 2017. Attendees were asked to consider the options to reconfigure Ophthalmology services provided at Sath. Representatives were invited and attended from Telford and Wrekin and Shropshire CCGs, Healthwatch, RNIB, Macular Society, patients and SaTH. Unfortunately members of the Welsh HB were invited however were not in attendance.

The outcome of the stakeholder are summarised below:

- The familiarity and confidence in the surroundings and floor plan was essential element and there was a very strong preference for one site where all tests and treatment could be offered in one appointment. Having all services at the same site was more important than any travel issues that might arise however representatives recognised that for some patients this would be challenging. There was concern from Telford and Wrekin Healthwatch that changes should not be made ahead of decision surrounding the Sustainable Services Plan however they did accept that further delay within a challenged service could harm patient users and also result in continued decline of the service. Telford and Wrekin commissioner agreed with the principle of centralisation but stated clearly that preference would be given to provide local care for their own population of patients.
- Opportunity exists to establish Centre of Excellence and develop services that mitigate risks that the Trust raised at the October 2016 risk review meeting chaired by NHS England. The outcome of the meeting was that a consensus agreement preferred the option of a single County Ophthalmology unit with centralisation of services.

7 TRUST BOARD VIEW

Following the feedback from the Stakeholder Engagement event the outcome was shared within a paper to Sath's open Trust Board meeting in April 2017 and a summary of the official minutes is provided below:

Mr Fox presented the following options to enable reconfiguration of the Ophthalmology service to address its substandard and fragmented accommodation; these opportunities would also support a reduction in workforce gaps and an improvement in team dynamics which are fundamental to the delivery of a sustainable service for the population of Shropshire, Telford and Wrekin and mid-Wales.

- Option 1 – Relocation of Clinic 10 into the Copthorne Building at RSH – this option has already been approved
- Option 2 – Reduce to two sites by closing Euston House with cataract surgery reprovided in Theatres 10 & 11 at RSH and all paediatrics relocated to MTX (portacabin) Building at PRH
- Option 3 – Reduce to two sites by closing Euston House with cataract surgery reprovided in Theatres within the Copthorne Building and all paediatrics relocated to the MTX (portacabin) Building at PRH
- Option 4 – Reduce to one site working at RSH with all adult services provided in the Copthorne Building and Paediatric Outpatient department within Copthorne and all paediatric surgery continuing at PRH
- Option 5 – Reduce to one site working at RSH with all adult services provided in the Copthorne Building and paediatric outpatient department with all paediatric surgery continuing at PRH
- Option 6 – Reduce to one site working at PRH

The Service Users identified that one site was crucial for service users because of the following:

- Familiarity and confidence in the surroundings and floor plan is essential;
- Very strong preference for one site where all tests and treatment could be offered in one appointment;
- Having all services at one site was more important to patients than travel issues that may arise as a result.

It was reported that Euston House do not fulfil the requirements for Health Education West Midlands cataract training; the suggested proposal would mean that cataracts would all be provided in the Copthorne Building in a purpose built daycase facility which would allow greater throughput and much improved and safer one-stop services. It would mean that around 22 patients per week from Telford ICAT (half of whom are Telford residents)

would receive their cataract treatment at Copthorne and all children from Shropshire would continue to receive their surgery at PRH, as at present. There is also a real opportunity to recruit and retain a high calibre workforce.

Mr Deadman (NED) queried if the organisation is 'slow to change or does it only change when a crisis is upon us'. He was informed that this is not specific to Ophthalmology; a change to a service takes time due to involving and engaging with the public. The FD reported that from his experience of working within the Trust over the past six years, he has found that there is an element of crisis management, however the Trust is moving to an improved vision.

The CEO commended the report stating it meets all safeguarding requirements, etc, and agreed that the organisation will go forward with the joint HoSC (Health Overview Scrutiny Committee).

Following discussion, the Trust Board APPROVED the following recommendations:

Phase 1:

- The relocation of Paediatric Ophthalmology Outpatients from Clinic 10 RSH to the Copthorne building (Ward 16) **and** as interim measure to move all paediatrics to MTX, PRH from 26th May 2017 for an interim period of 12 weeks;
- To relocate adult outpatient services from ICAT back to the respective main hospital sites
- To relocate cataract surgery from ICAT to Copthorne building

Phase 2:

- Following Purdah, to consider engaging with the public and relevant stakeholders to fully consult on the single site options identified, fully exploring cost and geographical location to implement a decision on these services but this would not preclude any decision arising from the Future Fit process.

Since the Trust Board approval in April 2017 Phase 1 (first bullet point) has been completed and Paediatric Ophthalmology Outpatients has been re-provided at RSH and PRH.

The department has been working on Phase 1 bullet points 2 and 3 and this paper outlines the engagement plan to seek a view on whether to proceed with:

- relocating adult outpatient services from ICAT back to the respective main hospital sites
- relocating cataract surgery from ICAT to Copthorne building

This engagement plan will **NOT** consider Phase 2 and will await the outcome of the future fit consultation.

8 ENGAGEMENT PLAN

This document outlines the engagement and communication plan. It is proposed that a 6 week period of engagement would commence in January 2019. This period will involve Eye Department services users, interested parties and staff. These persons will be asked to consider the options of Ophthalmology provision within the Trust particularly considering the option of reconfiguring services from 3 sites to 2 sites.

The Options; we are seeking the views of our local communities on the following two options below.

- Option 1: No change.
- Option 2: To relocate adult outpatient services from ICAT back to the respective main hospital sites and relocate cataract surgery from ICAT to Copthorne building.

Supporting Option 2 will result in the following changes. Those moved from ICAT are indicated in red type/italics.

Site	Outpatients	Surgery
RSH	**Adult** & **Paediatric** All sub-specialisms and Urgent Eye Clinic *Those outpatient services previously delivered at ICAT Adult.*	**Adult** General Anaesthetic and Local Anaesthetic sub-specialisms, complex and "simple". *Local Anaesthetic "simple" Cataract and Injections previously delivered at ICAT.* Emergency Operating.
PRH	**Adult** & **Paediatric** All sub-specialisms *Those outpatient services previously delivered at ICAT Adult.* **Excluding** the following: Urgent Eye Clinic Injections for Medical Retina related conditions Cornea Cataract assessment	**Paediatric** General Anaesthetic and Local Anaesthetic **Adult** Oculoplasty surgery.

We are seeking people's views via a questionnaire which can be accessed on https://www.sath.nhs.uk/wards-services/az-services/ophthalmology/ or via https://www.surveymonkey.co.uk/r/1810EyeCare . We will also be undertaking a programme of targeted engagement with patients using our eye department services across the current site configuration and we will be liaising with representative groups such as HealthWatch.

The engagement period will run for 6 weeks January/February 2019, and we would like to encourage people with an interest in Hospital Eye Services delivered at Sath to review the engagement document and complete the questionnaire.

The result of the engagement period will be analysed and will be presented to our Trust Board alongside associated recommendations regarding future temporary suspensions in a public Board meeting in April 2019.

9 ENGAGEMENT PROGRAMME OVERVIEW

The process

The engagement period will run for 6 weeks and during that time will seek the views of:

- local communities through a questionnaire, available online and in hard copy from the eye departments at PRH, Euston House and RSH

- Patients using Eye Departments through a programme of targeted engagement, which includes discussion groups. At these sessions attendees will be taken through the engagement document and asked to complete the questionnaire
- representative groups such as HealthWatch.

The result of the engagement period will be analysed and be presented to our Trust Board alongside associated recommendations regarding future temporary suspensions in a public Board meeting in April 2019.

The engagement document

At the core of the programme will be an engagement document which will clearly set out the basis on which we are engaging. It will set out: the purpose of the engagement programme and the dates of when it will start and finish; the operational pressures the service is under; the proposed future options for accommodation reconfiguration including the implications of no change, as well as what the results of change would look like in terms of benefits to patients and families and potential disadvantages; information about the engagement programme, and including how to respond.

The engagement document will be accessible, clear, concise and written in plain English. It will also be available in large font to aid those patients with sight impairments.

In addition to the engagement document, frequently asked questions will be produced during the engagement period. These will be used to provide answers to common issues and questions and respond to any issues that have arisen.

The questionnaire will be available on the Trust website and hard copies can be requested from the Care Group should anyone not have access to the internet. Hard copies will also be available across the Trust's Eye Departments.

Raising awareness and encouraging involvement

We would like to hear from local people and particularly patients and their families using our Hospital Eye Services to understand how we can best meet their needs. We are therefore proposing to raise awareness of the engagement period in the following ways:

- an initial announcement which will include a media release, letters to staff and stakeholders and social media content
- posters will be put up within our 3 Eye Departments as well as being provided on the information screens within the eye department at RSH
- eye department staff will be supported to talk to patients and families using the service to raise awareness and encourage involvement
- information will be available on the eye departments section of the website, and we will invite key partner organisations to signpost to it

Media approach

Our media approach will be proactive during the engagement period (as well as reacting, of course, to any enquiries or issues that arise). Across the county, the local media continues to be important in influencing public perception and reaction to all aspects of health and care changes and we will work with them and communicate key messages for the engagement through the channels they provide.

During the engagement programme we will adhere to the following key principles:

- Ensure we can provide clinical spokespeople wherever possible to explain the need for change, the options and next steps, and to support them appropriately in this role
- Work closely with local journalists and ensure they are fully briefed on the need for change, the options and next steps
- Respond to all media enquiries in a timely and helpful manner
- Regularly monitor the media and ensure that inaccurate information about the engagement programme is rebutted where necessary
- Evaluate all media coverage to assess its effectiveness, and the inclusion of our key messages, adapting our approach as appropriate.

Discussion groups

Stakeholder discussion groups will be held where patient representatives, staff, commissioners and other interested parties will be invited to attend. These discussion groups will use the engagement document to fully explain and discuss the current operational issues, the proposed options for consideration and to answer any questions. Participants will then be invited to complete the questionnaire.

We will aim to include those identified by the Equality Impact Assessment in discussion groups.

Questionnaire

Our questionnaire will be used to ask people for their feedback on the two proposed options, and to gather views and feedback on issues and concerns so that these can be understood, and taken account of, including mitigating where possible, in terms of decision-making and implementation of that decision. The engagement will also provide an opportunity to seek additional insight and ideas that may not have been considered so far.

We will send out the link to our questionnaire by email to a wide range of stakeholders and will also make hard copies available through our services. People will also be able to access the questionnaire via the Trust website and from our social media feeds.

Mechanisms for response

People will be able to respond to respond via a hard copy or online questionnaire.

Analysis of Engagement responses

The responses to the engagement will be analysed and a summary report will be presented to the Trust Board.

10 DIRECT ENGAGEMENT

Group	How	Aim
Eye Department Staff – clinical and non-clinical	• Face to face briefing sessions • Emailed information	• To ensure staff are equipped to communicate about the engagement

	• Updated as necessary throughout engagement period through internal communication channels – via managers and matrons etc.	and answer questions from service users • To encourage eye department staff to be involved as appropriate • Ensure all staff are aware of how to signpost service users who would like to have their say – discussion groups, online etc.
Stakeholder Engagement Discussion Groups	• Dedicated stakeholder engagement groups will be arranged and will include presentation of current situation, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and the distinction between this and the forthcoming CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure the group is aware of how to signpost service users who would like to have their say – meetings, online etc.
Health Watch / Community Health Council	• Attendance at specific meeting including presentation of current situation, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and the distinction between this and the forthcoming CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost service users who would like to have their say – discussion groups, online etc.
Joint Health Overview and	• Attendance at specific	• To provide an opportunity

Scrutiny Committee	meeting including presentation of current situation, detailed programme of engagement and hard copies of the survey to be made available, signposting to FAQs on website and online survey	for the committee to scrutinise the plans of engagement in line with our duty to consult and their role in reviewing and scrutinising matters relating to the provision and operation of local health services • Well briefed on the current position and able to communicate the facts • Ensure the committee is clear on the remit of the engagement programme and the distinction between this and the CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost service users who would like to have their say – meetings, online etc.
MPs	• Face to face or telephone briefing to include update on current situation, overview of engagement and to raise their awareness of FAQs and online survey	• Well briefed on the current position and able to communicate the facts • Ensure they are clear on the remit of the engagement programme and the distinction between this and the CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost women who would like to have their say – discussion groups, online etc.

11 REVIEW AND EVALUATION

The questionnaires will be analysed and a summary report will be used to inform a paper for the public Trust Board meeting in April 2019. It is intended that papers will be published as part of this decision-making process.

Eye
Stakeholder Engagement Event

Mr Tony Fox

Deputy Medical Director

Tuesday 25th June 2019

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Purpose

- Provide an overview of service improvement
- Opportunity for our patients and stakeholders to engage in dialogue. Feedback on patient survey.
- Consider service development surrounding accommodation

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Summary of Key Issues- March 2017

- Patient welfare and safety concerns
- Attracting and retaining workforce — Recruitment
  - Team dynamics and ability to train
- Inability to see patients within defined timescales
- Substandard/fragmented accommodation — Development
- Complex Patient Pathways — TCPS/VMI
  - leads to multiple/unnecessary attendances

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Patient welfare

Reduction of Serious Incidents

- Incidents in October/November 2017 related to Locums and third party providers.

Investment in people and time

- Failsafe Clerk to track and escalate
- Harm proforma review process
- VMI
- Human Factors Training

Executive Support

- Deputy Medical Director
- Clinical Director, Governance and Educational Consultant Leads
- Dedicated Operational Leaders

Capacity to deliver timely appointments remains extremely challenging.

Patient Pathways

- Collaboratively working with interested parties
- Improving internal pathways to ensure seamless patient flows
- Virginia Mason Value Stream **Ophthalmology Outpatients**
- Delivery of more one-stop services

Challenges with accommodation, site configuration and workforce limit the ability to fully implement.

Workforce

Workforce to deliver the required capacity remains extremely challenged

Fragile with regular turnover

- Supported by locums
- Insourced 3rd parties
- Ageing workforce/Health

Vacancies

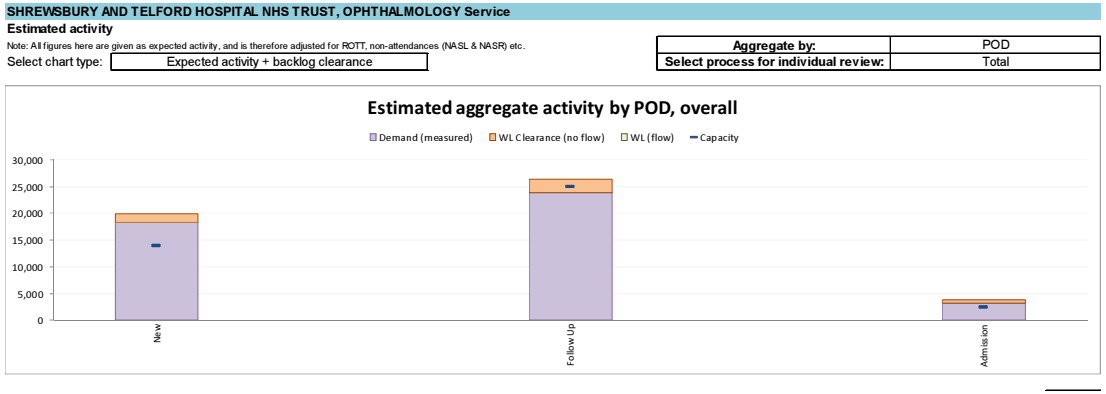
Vacancy (Whole Time Equivalents)	Consultants	Specialty Doctors
March 2017	3.5	2
January 2018	1.5 (1 medical retina)	1
June 2019	2.5 (2 commencing Q4 2020)	2 (interviews June 2019)

Actions taken

- Nurse and Optician delivered services implemented
- Consultant Gaps filled with locum consultants
- Remaining vacancies out to advert for doctors/nurses and new positions

Inability to see patients within defined timescales

- **Demand Exceeds Capacity (to meet demand we need to see an additional 3335 new, 632 FU, 381 surgery per annum)**



Actions taken

•Working collaboratively to improve patient pathways

•Suspension of new referrals for Glaucoma, General and Adult Squint Surgery- reopened April 2018 for Glaucoma and General

•Additional Capacity Insourced increasing from 500 slots a month.

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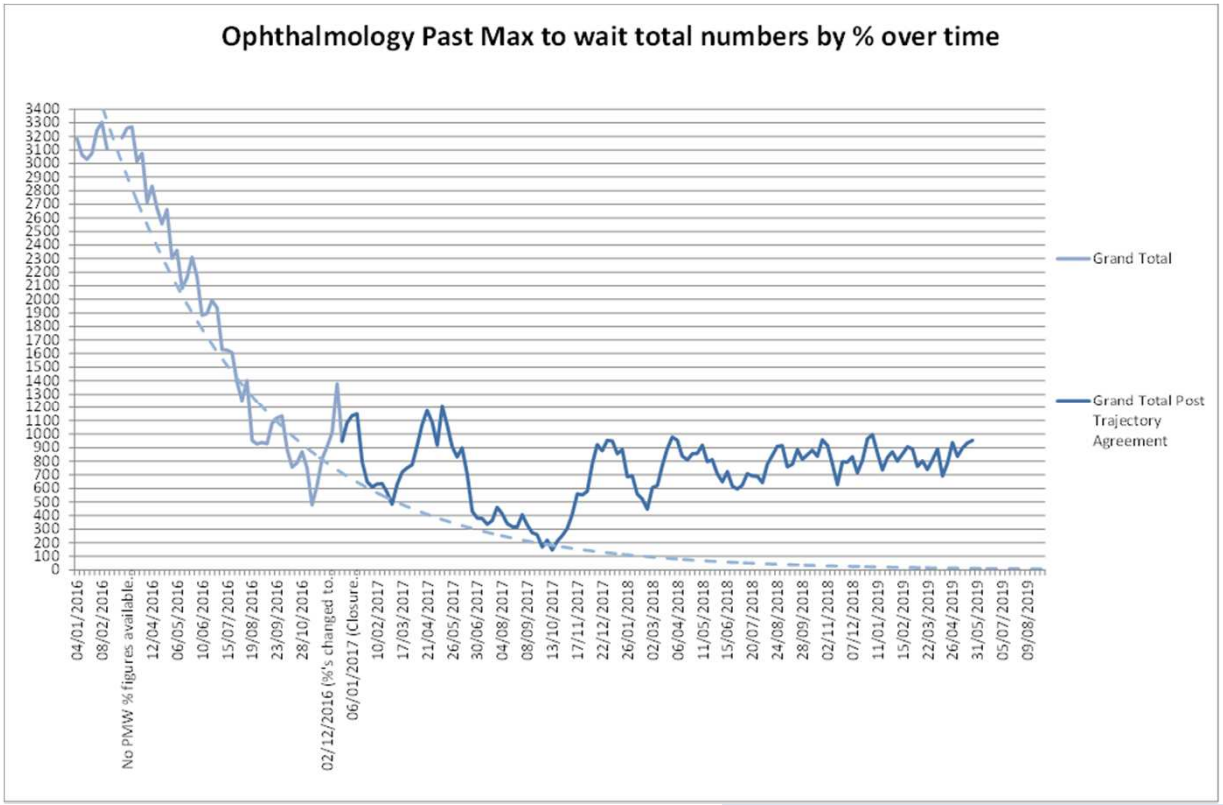
Reduced follow up waiting times



Count of Hospital Number	Column Labels						
Row Labels	0-25% PMW	26-49% PMW	50-99% PMW	100-149% PMW	150-199% PMW	200+ PMW	Grand Total
DIABETICS	42	1					43
GENERAL	13						13
GLAUCOMA	23	25	11	4		1	64
MEDICAL RETINA	129	11	2				142
ORTHOPTIST COMBINED	236	70	56	26	9	11	408
OTHER	21	14	50	44	15	37	181
PAEDS	15	12	8	3	2		40
PRASOS	2	1	1	3		1	8
VITRORETINAL	21	1		1		1	24
Grand Total	**502**	**135**	**128**	**81**	**26**	**51**	**923**

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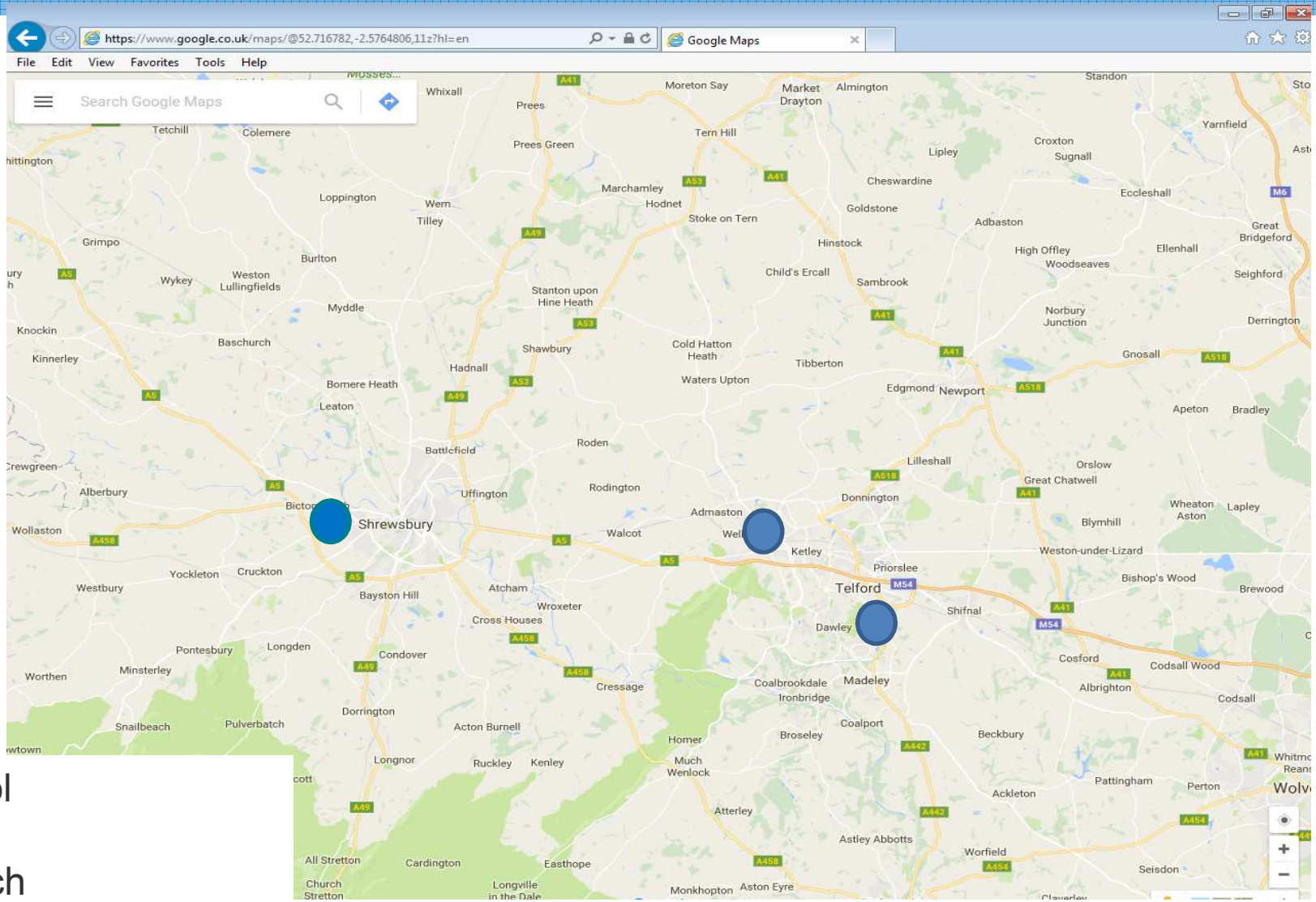
Current Site Configuration



Welshpool
Newtown
Whitchurch
Ludlow
Oswestry

Accommodation

- **Significant improvements at RSH-**
  - **26th June 2017 new adult outpatients opened**
  - **16th October 2017 new paediatric outpatients opened**
  - **Increased number of adult clinic rooms (from 6 to 13)**
  - **Increased number of Paediatric clinic rooms (from 2 to 6)**
  - **Dedicated diagnostic rooms**
  - **Improved flows and clinic throughput (work in progress)**
  - **Improved privacy, dignity and patient experience**
  - **Attractive for new recruits**

- **3 site working remains challenging**
  - Team working/Culture
  - Clinical supervision and inability to train
  - Inefficiencies – complex patient pathways

Princess Royal Hospital, Telford- MTX

- **Converted outpatient office Portable cabin not adjoined to main hospital**
  - 6 outpatient consultation rooms and 3 orthoptic designed rooms
  - Compliant for paediatric and adult patients
  - Ophthalmology Paediatric Operating Theatres (main hospital)
  - Remote Laser Room within main hospital building
  - Access to on-site emergency service/resuscitation team for paediatric and adult patients

- Dedicated receptions, car parking available (charged), Wellington train station near by.

- Catering/Restaurant located within Princess Royal Hospital Site

- Limited lifespan for portable cabin.

Euston House, Telford

- **Converted office accommodation**
  - 3 outpatient consultation rooms (6 down to 3)
  - Main diagnostic equipment available
  - Not compliant for paediatrics
  - No on-site emergency service/resuscitation team

- **Surgicube theatre for cataracts**
  - Does not allow training
  - Design limits maximum patient throughput (average 5-6 cases)
  - Specifically trained Ophthalmology theatre staff

- Close to train station, Shared reception with small waiting area, free but limited car parking, no on-site catering facility

Reconfiguration of Eye Services

March 2017 and January 2018 Stakeholder Events

- Familiarity and confidence in surroundings and floor plan essential.
- Strong preference for one site. All tests and treatment ONE STOP
- This was more important than travel related issues
- Recognition that for some patients this would be challenging

April 2017 SaTH Board- Approved

1. Relocation of Clinic 10 RSH to Copthorne
2. Agreed in principle to close Euston House
    - Relocate Adult Outpatients Services to respective hospital sites
    - Relocate Cataract Surgery from Euston House to RSH
    - Subject to further engagement following HOSC review

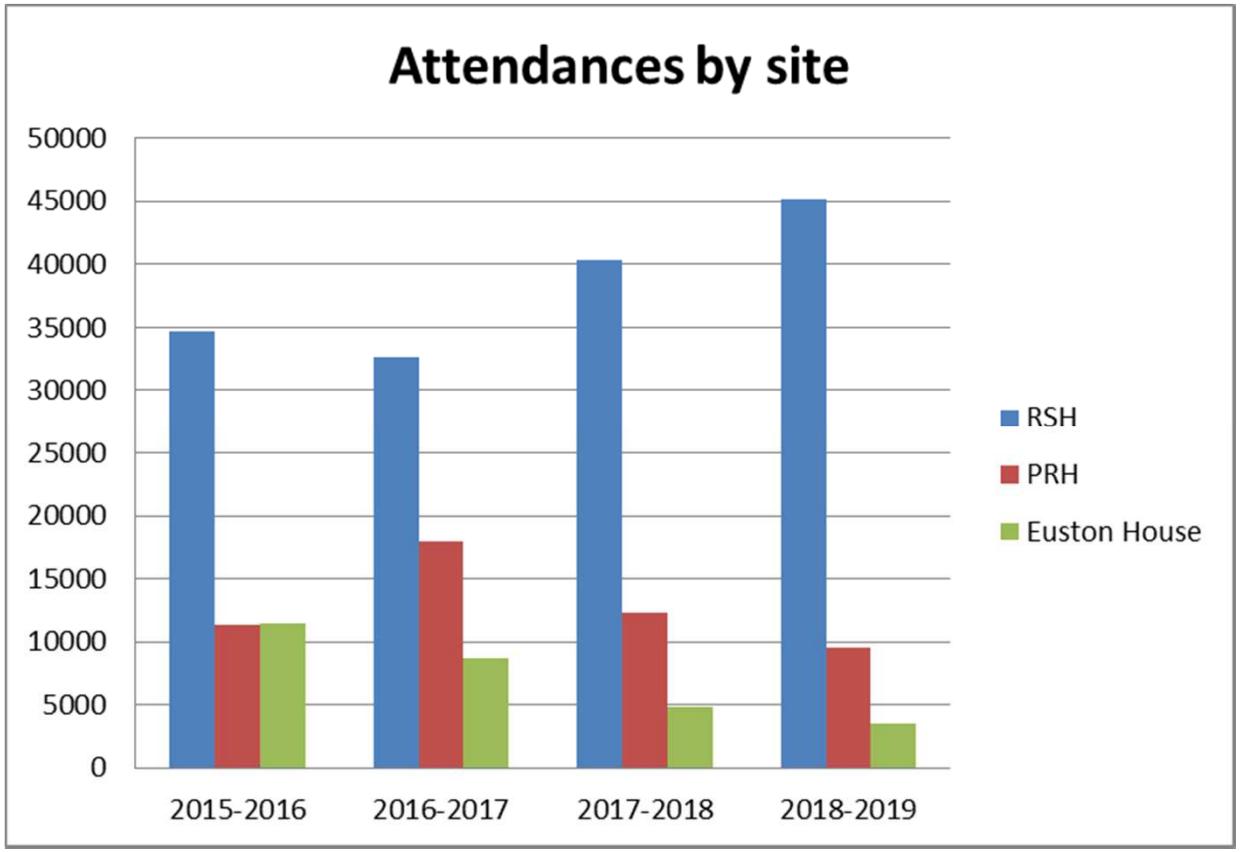
HOSC meeting January 2019

- Welcomed the overview of service provision and challenges
- Impact of closing Euston House Telford and Wrekin patients
- Supported plans for further engagement and feedback on survey results

Further Considerations

- Insufficient rooms at Euston House to accommodate multi disciplinary clinics
- Staff isolated from main units
- Travel time for staff (reduction in patient facing time)
- Inability to expand greater volume of cataract work (GIRFT)
- Inability to train (HEE triggered review)
- NHS Property Services rental for Euston House

Attendances by site



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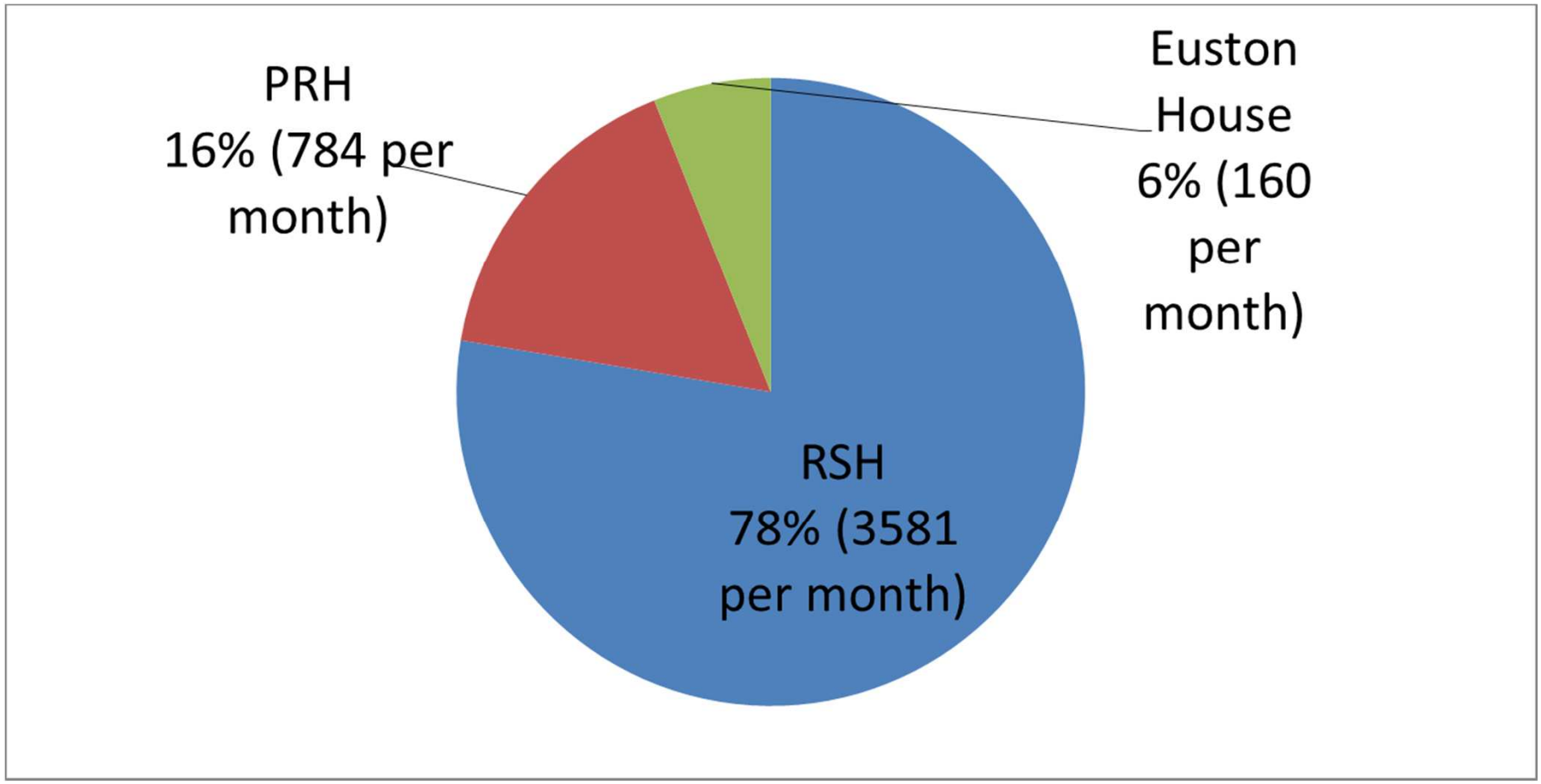
Monthly Outpatient attendances



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Reconfiguration of Eye Services- Survey Results

Survey carried out February/March 2019 following a trial in the eye clinic at RSH

Sent to stakeholders, commissioners and 162 Community and Voluntary Sector organisations with a request to distribute wider.

Link provided on SaTH website Ophthalmology pages, promoted through social media and print media.

Paper copies distributed to the 3 hospital sites along with pop up stands. Staff briefed and supported patients to complete where required.

Sample analysis

- There was a total of 267 responses to survey
- 61% were responses from patients who had been seen at one of our clinics (that day)
- Respondents demographics:
  - Telford &Wrekin 48.63%
  - Shropshire 43.53%
  - Mid-Wales 7.45%
  - Out of area 0.39%

Key findings

- 85% of patients would prefer to have one longer appointment rather than several shorter ones
- How patients got to the hospital appointments at RSH, PRH and Euston House:
  - 76% patients travelled by car
  - 11% Public transport
  - 4% using non emergency patient transport
  - 3% Walk
  - 2% Taxis
  - 1% volunteer drivers/Community Car scheme
  - 0.5% cycling
  - 2.5% Non Specified

Main themes from Qualitative Responses

- A total of 115 comments were received on the survey. The main themes of the comments are identified as:
  - Transport and Travel times
  - Service experience
  - Staffing

Travel and Transport

- Difficulties for patients using public transport from rural areas.

- Example provided of a patient from North Shropshire was is unable to get to their local hospital (PRH) due to no public transport going to Telford

- Car parking charges and lack of parking at the hospital.

Service Experience

- 65% of all the comments received were positive, many describing the service they received as excellent
- 27% of patients reported less favourable experiences, some of these were historic, some were in relation to third party providers
- Of the concerns raised in relation to the service provided by the Trust, respondents were able to leave their contact details for Ophthalmology to contact them directly
  - 12% of respondents chose to do so.

Staffing

- There were no negative comments about staffing. However many respondents commented about the service they had received from staff.
- 80% of comments were positive and described staff as “very friendly and most helpful”
- Respondents commented that the service could be improved by seeing the same consultant for continuity of care

Group Task

Questions to answer:

- What benefits and disadvantages of the proposed plans?

Consider:

- What have we missed in the proposed plans?
- What are your on going concerns?
- What can we do better?

Summary of next steps

- Summarise the feedback from this session
- Complete a Quality and Equality Impact Assessment Session
- Present to HOSC and the Trust Board
- Implement changes as directed
- Work with you towards continuing to improve services for patients

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Activity Levels

Adults

Financial Year	RSH		PRH		Euston House	
	Outpatients	Surgery	Outpatients	Surgery	Outpatients	Surgery
2015-2016	29115	1884	6208	64	10114	1323
2016-2017	27486	1657	12920	58	7516	1134
2017-2018	34891	2693*	6488	58	3901	924
2018-2019	38752	2189	4877	27	1926	1589

* in 2017-2018 SaTH commissioned Nuffield Health to provide 115 surgical cases which are included within the RSH figures.

Paediatrics

Financial Year	RSH		PRH		Euston House	
	Outpatients	Surgery	Outpatients	Surgery	Outpatients	Surgery
2015-2016	3726	10	4973	149	13	0
2016-2017	3434	3	4864	66	17	0
2017-2018	2734	1	5748	54	3	0
2018-2019	4219	7	4533	65	5	0

Overall 2018/19

54312 Outpatient Attendances= 79% RSH, 17% PRH, 4% Euston House

3877 Surgeries= 56% RSH, 2% PRH, 40% Euston House

Closing Euston House would mean:

576 were telephone appointments and not actual visits so unaffected.

Thus 1355 patients attending Euston House in 12 months (113 a month).

Of the 1355, 142 have an SY post code, 1122 TF postcode and 91 others (Wolverhampton, Stafford, Dudley, Stoke, Teeside, Llandrindod Wells).

Of the TF Postcodes (1122), 586 (52%) Outpatient appointments could be provided at PRH and 536 (48%) appointments at RSH

1589 operations would transfer to RSH. 582 have an SY postcode, 910 TF postcode and 97 other.