

**Report on the staff engagement exercise for the Maternity and
Newborn Services Review
January – March 2007**

Contents

1. Summary
2. Introduction
3. Profile of Meetings
4. Profile of correspondence
5. Normal Childbirth / Reducing Interventions
6. Patient Choice and the Provision of Local Services Close to Home - Including the role of community based, midwife- led birth centres
7. Physical Access to Facilities
8. Staffing, Resources and Training
9. Relationships Between Professional Groups
10. Continuity of care
11. Patient Safety
12. Targeted Services for certain BME and vulnerable groups
13. Neonatal Services
14. Miscellaneous Comments
15. The Royal College of Midwives
16. Validation of Objectives
17. Conclusion

Appendix 1: Details of meetings held and attendance

Appendix 2: Full feedback from consultant neonatologists

Key

BHSP	Bristol Health Services Plan
BRHC	Bristol Royal Hospital for Children
BME	Black and Minority Ethnic
EWTD	European Working Time Directive
NBT	North Bristol Trust
NCT	National Childbirth Trust
NICU	Neonatal Intensive Care Unit
NHS	National Health Service
OSC	Overview and Scrutiny Committee
PALS	Patient Advice and Liaison Service
RCM	Royal College of Midwives
TCF	The Care Forum
UBHT	United Bristol Healthcare Trust

1. Summary

- 1.1 The staff engagement period of the Maternity and Newborn Services Review ran from 1 January 2007 to 1st April 2007 as part of the Bristol Health Services Plan (BHSP).
- 1.2 In total 159 people took part in 17 staff meetings. The Primary Care Trust (PCT) has also recorded 18 pieces of correspondence. All of this data has been entered onto a database, which will be made available to the BHSP office.
- 1.3 The following key topics emerged from the staff engagement exercise and will be considered in detail in this review;
- Normal Childbirth / Reducing Interventions
 - Patient Choice and Provision of Local Services Close to Home - Including the role of community based, midwife- led birth centres
 - Physical Access to Facilities
 - Staffing, Resources and Training
 - Relationships Between Professional Groups
 - Continuity of care
 - Patient Safety
 - Targeted Services for certain Black and Minority Ethnic (BME) and vulnerable groups
 - Neonatal Services
- 1.4 For the purpose of this report, Neonatal Services will be considered separately in a distinct section, although comments made by the neonatal consultants and nurses on other areas of maternity and new born services will be considered in the relevant sections.
- 1.5 For the purposes of this report, the feedback on each topic outlined above, will be clearly separated into the distinct staff groups, these staff groups have been identified as;
- Consultant Obstetricians
 - Consultant Neonatologists
 - Hospital Midwives and Nurses
 - Community Midwives
 - Other Staff Members (including Public health professionals, General/support staff, General Practitioners (GPs) and a physiotherapist)

2. Introduction

2.1 Purpose of the Review and the Role of the Staff Engagement Phase

It is the stated intention of the BHSP Maternity and Newborn Services Review to ensure that every parent and baby has the best possible experience of birth and early days. To do this the review has invited comments from staff, including both those who are directly involved in provided maternity services in the local area, and those that are not directly involved, but would like to input their comments into the review. The ultimate purpose of the review is to come up with a recommendation on how best to provide maternity and neonatal services in the future. A short list of options of how these services could be provided in the local area in the future will be compiled from the staff and public engagement feedback, along with other local and national information. This list of options will then go out to public consultation before a preferred option will be taken to the NHS Trust Boards for a final decision.

Staff were invited to feedback their views on the current provision of maternity and new born services either via individual correspondence or via group meetings. Staff were asked specifically to respond to the following questions;

- What do you think of the current services?
- What is good?
- What needs changing?
- What sort of things really matter to you?
- Is there anything else you want to tell us or to suggest?

2.2 Objectives of Review

Clear objectives for the maternity and newborn services review have been established and these objectives are to;

- Promote normal childbirth
- Promote choices for where, and how, mothers give birth
- Provide safe and effective care to national standards
- Reduce inequalities
- Make best use of resources, ensuring that services are affordable
- Attract and retain staff by offering good experience and opportunities for development

This report will consider, how far the feedback from staff in the staff engagement phase of the review validate, or contradict the objectives stated above.

3. Profile of Meetings

3.1 Number and types of meetings held

3.1.1 Between 1st January 2007 and 4th April 2007, 17 staff meetings were held. Each meeting was targeted towards a particular staff group, and members were invited from all of the interested organisations. Feedback was invited in meetings for the following staff groups; Neonatal Intensive Care Unit (NICU) midwives, support staff, consultant obstetricians, neonatal nurses, consultant neonatologists, hospital midwives, community midwives, general staff and the public health network. In addition separate meetings were held for the Royal College of Midwives (RCM) and the Joint Union Committee.

3.1.2 Appendix 1 provides full details of the meetings held and the attendance at each meeting.

4. Profile of Correspondence

4.1 18 pieces of correspondence were received as part of the staff engagement process. These consisted of 9 e-mails, 7 feedback forms, 1 telephone call and 1 letter.

Types of correspondence	Number of items received
E-mail	9
Feedback forms	7
Telephone calls	1
Letters	1
Total	18

Table 1. Correspondence received

5. Normal Childbirth / Reducing Interventions

Consultant Obstetricians

5.1 There was a consensus that, *“the high and increasing caesarean section rate is wrong”* and that, *“there should be no unnecessary caesareans”*, there was no agreement, however, on how this could be achieved.

5.2 Along with politics and finance, the high caesarean section rate and the lack of normal birth were considered by this group as the major drivers for change.

Community Midwives

- 5.3 It was widely agreed amongst community midwives that childbirth has become over medicalised and that the level of medical interventions is rising to an unacceptable level. It was also agreed that women are often giving birth in consultant led, hospital units when there is not the medical necessity.
- 5.4 The need for an increase in the normalisation of birth and the numbers of normal deliveries was unanimous throughout the feedback, both through staff meetings and through individual correspondence.
- 5.5 One midwife stated that, *“I have been witness to the phenomenon of the ‘cascade of interventions’ where a potentially normal event becomes an abnormal one because of an intervention that was done ‘just in case’.*
- 5.6 Another midwife commented that, *“The medicalisation of pregnancy and birth has led to women being subjected to a barrage of unnecessarily and often harmful interventions”.*
- 5.7 It was widely stated amongst community midwives that there is currently a dominance of the medical model of maternity and newborn care and that there is a concentration of birth in acute units, with an emphasis on the technological at the expense of the emotional and the social.
- 5.8 It was suggested by one midwife that caesarean section rates are also increasing due to the increasing rates of obesity, diabetes and other medical conditions.
- 5.9 It was suggested that an increase in the number of mid-wife led birth units, along with the greater utilization of those that already exist could help reduce the levels of medical intervention and further promote the ‘normalisation’ of birth.
- 5.10 It was also suggested that there could be Consultant Midwives with a primary focus on ‘normality’, who could ‘troubleshoot’ on the birth suites, main obstetric unit and in the community, helping all staff members and women to understand childbearing for the *“normal life event that it mostly is”.*

Hospital Midwives

- 5.11 Increasing the number of normal births was seen as a priority amongst hospital midwives. One midwife suggested that, *“in order to increase the number of normal births and reduce the caesarean section rate, women and health care professionals need to increase confidence with reduced intervention”.* It was commented that in order to reduce the level of interventions and increase normal birth, real one-to-one support for women is needed, but that staffing

levels would need to increase for this to be possible. In addition, supporting junior doctors and midwives in gaining confidence in not intervening too quickly and critically reviewing all cases where a caesarean section was performed to determine how appropriate it was, were considered to be measures that could help to normalise birth.

- 5.12 It was raised by hospital midwives that there has been an increase in abnormal pregnancy complications due to factors such as older women giving birth, rising number of women with a high Body Mass Index (BMI), women with congenital heart problems giving birth and that this is increasing the number medical interventions necessary.

Other Staff

- 5.13 The public health network noted that lower medical intervention rates were preferable and that one to one midwifery care should help to achieve this.

6. Patient choice and provision of local services close to home – including the role of community based, midwife- led birth centres

Consultant Obstetricians

- 6.1 It was noted that Southmead has already increased patient choice and made a significant change by providing a Birth Suite.
- 6.2 It was suggested that more evidence is needed before new birth centres are built.

Consultant Neonatologists

- 6.3 It was agreed that in principle the consultant neonatologists support in principle the, “*choice that a birth centre gives parents of low risk pregnancies*”, however, for this group the following points would need to be considered;
- Admission criteria, delivery and postnatal care of the newborn infants in a birth centre should be subject to the same rules in terms of standard of care, and evidence based practice, clinical governance etc as all other areas of the NHS and should include input from obstetric and neonatal teams.
 - Birth centres should ideally be adjacent to the provision of specialist Obstetric and Neonatal Care.
 - Parents need to be aware of the potential risks involved in delivering in a birth centre.
 - The staff at a birth centre should have training in resuscitation that complies with National Guidance.

- There should be provision for the emergency transfer of mothers and babies from a birth centre to a specialist unit if the situation arises.

Community Midwives

- 6.4 It was considered by a number of community midwives that current services are “*generally good but there is a lack of choice*”. Choice was widely considered as very important to maternity and newborn services with one midwife stating that, “*I feel passionate that women must have a range of choices*”.
- 6.5 One community midwife believed that, “*current services are good and do offer women choice about their place of birth*” and detailed how women in her area are able to choose to give birth in a variety of different consultant-led and midwife-led units, including being offered the option of a water birth or to give birth at home. In addition these women are also given a choice of their lead professional for antenatal care.
- 6.6 It was questioned by staff members in several of the meetings for community midwives and via individual responses whether women in Bristol have ‘real choice’. For example, it was felt that the birthing unit at St Michael’s is not a real choice because staff from the birthing unit get pulled across to the consultant led Delivery Unit, resulting in there not being enough staff in the birthing unit for women to give birth there. This was also considered to be a problem at Southmead, but to a lesser extent. It was widely felt that greater use needs to be made of the existing birthing units at UBHT and at NBT. It was also considered by some that these birthing suites need to be more autonomous and function independently of the on-site consultants.
- 6.7 It was widely agreed by community midwives, commenting through meetings and individually that there was a need to, “*improve local provision in midwifery-led units*”. And that women need to be made aware of the potential benefits of giving birth at home, in a birth suite or in a stand alone, midwife-led unit.
- 6.8 A number of community midwives stated the need for a “*stand alone Birth Unit with facilities for community midwives, Health Visitors and other community personnel to use for such things as births, antenatal clinics, parent prep sessions, teenage mothers support groups etc*”. It was stated in individual correspondence and via the staff meetings that this model of unit would help to improve rates of ‘normal birth’ as well as provide local services close to a women’s home. One midwife stated that, “*A network of community-based, midwife-led birth centres, available as a choice to all of the women of Bristol, has the potential to address all of the shortcomings listed*”

Neonatal Nurses

- 6.9 It was agreed that the Birthing Unit at St Michael's needs to be made *"more home like"*.
- 6.10 The neonatal nurses from UBHT noted that if an additional Birth Centre was established there would be, *"knock on costs, such as a retrieval service for babies needing neonatal care. 1 in 10 babies need extra support and we can't always predict who they will be."*

Hospital Midwives

- 6.11 It was commented that services needed to suit the local population and that there is a need for more accessible services for vulnerable client groups.
- 6.12 One hospital based midwife suggested that wider access to local midwife-led units, accompanied by a campaign to promote their use, could help to increase the number of 'normal births' in the area.
- 6.13 It was commented by one group of hospital midwives that the choice of giving birth in Weston needs to be more widely promoted, by GPs, local press, obstetrician and midwives. It was noted that many women living in Weston are currently not choosing to give birth there and it needs to be understood why this is the case. It was suggested that clearer messages about the Weston birth centre not having obstetric services on site need to be given to women, as currently there is a lot of confusion, which is leading to reduced confidence in staff at Weston.
- 6.14 Hospital midwives at NBT commented that the birth suite at Southmead was promoted as a choice to women, but that because of low staffing, it was not always possible that women could give birth there.

Other Staff

- 6.15 A physiotherapist highlighted the high quality of services provided by the two teaching Trusts in Bristol, but raised concern over the services provided at Weston. In particular concern was raised that there is no consultant-led service on-site if something goes wrong and that the facilities in Bristol are too far away should this happen. Concern was also raised over the role of midwife-led birth centres stating, *"I cannot see how these will be cost effective. It will cost to set up, build the unit and staff them"*.

7. Physical Access to Facilities

Hospital Midwives

- 7.1 It was agreed by this group that access to St Michael's hospital is very poor and that in particular, there is inadequate parking for family, visitors and staff. One hospital midwife commented that, *"The hospital is an absolute nightmare to get to and an even bigger nightmare once you do get there in terms of parking and access. To be walking up and down St Michael's Hill whilst pregnant, or with a baby, having had a section, would be awful and near on impossible"*
- 7.2 One hospital midwife expressed the view that the centralisation of services at UBHT would be *'disastrous'* due to the poor access.
- 7.3 It was suggested that a park and ride scheme for staff could be a solution and that this, along with parking is needed out of hours and not just 9-5.

Other Staff

- 7.4 It was raised in a meeting of health care assistants and support workers that travel and access to Southmead is very good and that parking at Southmead is much better than at UBHT.

8. Staffing, Resources and Training

Consultant Obstetricians

- 8.1 Concern was raised over the impact of an increase of midwife-led birth centres and home births on the training of junior medical staff. It was suggested that this increase would mean that trainees will not get the necessary experience of 'normal birth'. It was suggested as a solution that as part of their training, trainees could spend a session in the midwife-led units to redress the imbalance.
- 8.2 The group expressed concern over the potential impact that having a single, large unit could have upon staffing and hours for obstetricians.

Community Midwives

- 8.3 Staffing levels amongst community midwives was widely viewed as a concern, with one midwife stating that *"midwives are leaving the profession faster than they can be replaced"*. It was widely felt that an increase in the numbers of community midwives was needed to address the following points and to achieve some of the improvement identified;

- More assessments of women in their own home can help to reduce early admission to hospital.
- To support the increasing numbers of home births and provide a good standard of care.
- To deliver adequate antenatal care.
- To provide birth planning sessions.
- To provide full postnatal support, including spiritual, emotional or breast feeding support whilst in hospital and to provide the adequate number of home visits in the community.

8.4 One community midwife suggested that with an increasing number of women electing to leave hospital early, there has been an subsequent rise in the level of postnatal care provided by midwives in the community and that adequate staffing levels are needed to maintain good standards of care.

Hospital Midwives

8.5 It was considered that more resources were needed in general, with income following activity.

8.6 One hospital midwife commented that, more time and resources dedicated to providing accessible information to help women in making decisions (including in other languages) is needed.

8.7 One group of hospital midwives questioned whether it might be more efficient to use resources to employ more midwives and fewer obstetricians.

8.8 It was noted that the workforce is changing with many midwives getting close to retirement age and with this, staff with experience are being lost. It was felt that amongst newer members of staff, there is less interest in working on-call and a 'work / life balance' is viewed as more important.

8.9 It was commented that the role of teaching and training for midwives needs to be considered in the outcome of the review and that UWE needs to be included in any discussions over the range of experiences encountered as a part of training.

8.10 Concern was raised by one group of hospital midwives around midwifery training and mentorship and in particular it was noted that direct midwifery training affects midwife practice.

8.11 It was suggested that extra resources need to be allocated to develop support roles to take on more responsibility and undertake more elements of the birth.

- 8.12 Hospital midwives at NBT noted that having an integrated hospital and community service means that staff can rotate between the two which is good for training.
- 8.13 It was suggested that community midwives currently do not have enough administrative and IT support and that these midwives spend time doing administrative work, which leaves less time to spend providing other services.
- 8.14 It was commented that more resources are needed to provide staffing for more home births.

Other Staff

- 8.15 One GP commented that, *“our community midwife is excellent. I believe if she was not so very overworked she could do more home deliveries and have time for better liaison with the HV team for families of concern”*.
- 8.16 The public health network commented that there is a concentration of service configuration, but that the, *“major issues for the maternity service boil down to the number of midwives. If we had more then the quality of service would increase”*.
- 8.17 The public health network suggested that skill mix within the workforce is a key issue and that new idea such as midwifery support staff should be explored and that training and development of staff is key. It also emphasised that it is critically important to only look at options which we can deliver from a workforce perspective.
- 8.18 Support staff and health care assistants raised that there needs to be more theatres to cope with the rising rate of caesarean sections being performed.
- 8.19 Support staff and health care assistants stated that there is a need for more staff in general, but specifically that it is a 24 hour service, but that there are only receptionists working between 7.30-3pm and after that health care assistants have to cover reception, which is not adequate. There needs to be an assessment of skill mix and whether the most effective use of staff is being made.
- 8.20 The public health network commented that it would be worth exploring the impact of team midwifery on antenatal admissions and postnatally, e.g. breastfeeding.
- 8.21 Support staff and health care assistants stated that the Reception desk and area on the delivery suite at Southmead needs to be refurbished and that there needs to be more meeting room and staff facilities, including toilets in the unit.

8.22 It was raised in a general staff meeting that there is a need for a trained pathologist at UBHT because current delays are impacting on the quality of care.

9. Relationships Between Professional Groups

Community Midwives

- 9.1 The quality of professional relationship, both within and between professions was seen as very important to a number of community midwives.
- 9.2 Working relationships amongst midwives was viewed very positively, with one midwife stating that, *“I am empowered while working in the community and practice professionally and autonomously within a fantastic group of midwives, who support each other and respect each other”*.
- 9.3 It was raised that because of the nature of their work, community midwives can often be geographically isolated from colleagues and that it is key that expertise and skills are widely shared between professionals.
- 9.4 Productive relationships between different groups of staff was viewed as key to providing high quality care to mothers and babies. One midwife commented on how there needs to be recognition and respect of expertise and skills from different areas, eg consultants and midwives. It was also noted that there was a need for there to be good communication and respect amongst multidisciplinary teams.

Hospital Midwives

- 9.5 One group of hospital midwives suggested that currently organisation boundaries can get in the way of providing care and commented that, *“we are all part of the same NHS – so we should all work together”*

Other Staff

- 9.6 A PCT staff member commented that services need to link more closely with support services in the community to ensure good emotional and mental health, & to help keep breast feeding rates up and to boost confidence.
- 9.7 The public health network suggested that interfaces between midwifery and other services can be problematic, e.g. mental health pathways and relationships with GPs need to be considered.

- 9.8 In a general staff meeting it was raised that there needs to be *“effective interface between gynaecology and midwifery, e.g. better understanding of roles.”*

10. Continuity of care

Community Midwives

- 10.1 Continuity of care was seen as very important to community midwives, responding through the staff meetings and through individual correspondence. One community midwife stated that, *“it is my privilege to see women through their antenatal, intrapartum and postnatal periods”* and another stated that currently, *“services are fragmented and women do not get continuity of care.”*

Hospital Midwives

- 10.2 One hospital midwife commented that an increase in the number of community midwives with a realistic caseload could improve the continuity of care for women and babies. It was commented that. *“The more continuity of care women have, the more confident they are likely to be in pregnancy, labour and postnatally. Continuity of carer is also safer and more efficient”.*
- 10.3 One group of midwives commented that parents having a named midwife throughout the whole pregnancy, birth and postnatal period is key to providing continuity of care.

Other Staff

- 10.4 The public health network noted that, *“continuity of care by a midwife and adequate preparation (including unit tours, antenatal classes) is helpful to mental well being.* It was also suggested that tours of maternity units need to be reinstated for perspective parents as virtual tours have proved insufficient.

11. Patient Safety

Consultant Obstetricians

- 11.1 It was concluded that birth centres that are attached to consultant units seem to provide the safest care, although there is no evidence that one birth place is safer than another, as only certain outcomes can be measured (such as caesarean rate).

11.2 There was concern expressed over receiving patients from non-medical settings because of a lack of clarity over where indemnity starts.

Hospital Midwives

11.3 One group of hospital midwives commented that, "*Safety of women and babies matters, we must get this right*".

12. Targeted Services for certain black and minority ethnic (BME) and vulnerable groups

Community Midwives

12.1 It was raised in one meeting of community midwives that there was the need for a better interpretation service and that parent craft does not meet BME needs in certain areas. In addition it was raised that, "*Antenatal services are aimed at the average middle class mother*" and it was questioned whether the needs of teenage mothers or people with learning difficulties are being met and although some groups of women are being targeted, others are not. It was suggested that the skills of those with specific knowledge of certain groups of women (eg some BME communities) need to be more effectively utilized.

Hospital Midwives

12.2 It was commented by a group of hospital midwives that the current translation service is not adequate and that there needs to be more translators and that the language line, Out of Hours is not always adequate.

12.3 There was a suggestion that women from BME groups need to be encouraged to become midwives and that more link workers between midwives and communities would be useful and there needs to be better communication and understanding of some BME communities. It was also noted that adolescent medical and antenatal care needs to be a priority as these are also a vulnerable group.

Other Staff

12.4 The public health network suggested that there was the potential to recruit midwifery support staff from hard to reach groups, such as BME and people from Eastern Europe. It was suggested that these could fulfil a range of roles such as link workers, health educators, language advocates etc.

12.5 The public health network commented that there needs to be an expansion of the refugee clinician programme.

13. Neonatal Services

Consultant Neonatologists

13.1 What is good about the service?

- a. Consultant led/delivered service
- b. All services except for Extra Corporeal Membrane Oxygenation (ECMO) provided in Bristol
- c. Parents have a high regard for the service
- d. St Michaels' and Southmead can provide limited parent accommodation to Bristol, North Somerset and South Gloucestershire (BNSSG) and non BNSSG parents

13.2 What needs changing?

Presently the NICU service in Bristol is provided by two level 3 NICU's (St Michael's and Southmead). Specialist services (e.g. surgery, radiology and cardiology) are provided at a third location Bristol Children's Hospital. The Bristol service does not comply with all of the standards below. These are National standards upon which the configuration of a neonatal service should be based;

1. Report of Department of Health (DH) expert working group on Neonatal Intensive care Services 10th April 2003
(see <http://www.dh.gov.uk/Home/fs/en>)
2. BAPM – Standards for Hospitals Providing Neonatal Intensive Care and High Dependency Care (2nd Edition) December 2001 (see <http://www.bapm.org/publications/index.php>)
3. Project 27/28 CESDI – An enquiry into quality of Care and its effects on the survival of babies born at 27-28 weeks gestation
(<http://www.cemach.org.uk/publications.htm>)
4. Designing a Neonatal Unit – Report for the British Association of Perinatal Medicine 05/2004 (see <http://www.bapm.org/publications/index.php>)
5. National Service Framework for Children, Young People and Maternity Services 09/2004
(see <http://www.dh.gov.uk/Home/fs/en>)
6. Postnatal care: Routine postnatal care of women and their babies; National Institute for Health and Clinical Excellence (see <http://www.nice.org.uk/guidance/CG37>)

13.3 In general terms regarding changes

“Every patient should have equitable access to specialist advice and care e.g to cardiology, surgery, other medical specialities, radiology, laboratory, pharmacy, physiotherapy, dieticians, infection control” (item 5.6 of BAPM 2001 standards)

13.4 Specifically changes need address:

Cot Capacity, Medical and nursing staff levels, location of the service, design of the neonatal unit and transport of newborn infants. These are dealt with in turn below. In addition we have commented on the proposal to have birth centres in Bristol

13.4.1 Capacity – increase in cot capacity

- Insufficient cot capacity to accommodate newborn infants who need NICU care from BNSSG/Non BNSSG areas for all levels of NICU care and specialist services (e.g. cardiac, surgical, neurosurgical, nephrology)
- British Association of Perinatal Medicine (BAPM) standard 4.5 suggests that a cot occupancy level average of 70% allows a unit to accommodate peaks in demand, lower infection rates and reduced mortality (currently both units run at >100% occupancy for 25% of time). This excess occupancy might contribute to mortality of newborn infants.
- Sufficient capacity to minimize the inappropriate transfers of mothers and newborn infants from both NICU

13.4.2 Staffing – increase in nursing and medical staff

- BAPM standard is for 1 nurse per level 1 cot; 1 nurse per 2 level 2 cots; 1 nurse per 4 level 3 cots (this would reduce newborn mortality in newborn infants with a non lethal abnormality by 50%)
- Consultants at both sites work above the hours stated in the European Working Time Directive (EWTD). If there was a requirement to reduce these hours, this would require the appointment of more Consultants
- Junior medical staff currently work in line with the EWTD but as the EWTD recommended hours reduce, the numbers of junior medical staff will need to be increased
- The current and future provision of undergraduate and postgraduate teaching at both units has an impact on the availability and flexibility of delivering the clinical service.

13.4.3 Location

- Ideally the NICU service would be physically attached to the specialist services that it requires (e.g. surgery, radiology and cardiology, physiotherapy, dietetics etc)
- Alternatively, if the NICU service remains located at St Michael's and Southmead with specialist services at Bristol Children's Hospital there would need to be a 24 hour emergency transfer service between these units. The current dedicated transport service only operates within UBHT and runs from 0800 – 2200h, there is no dedicated transport service for Southmead.

13.4.4 Design

- Standards for the design of a new NICU service are in the BAPM document
- The NICU units should be able to cope with the need to isolate newborn infants when they are admitted from another NICU unit or need to be cohorted when there is an infection control issue (e.g. Methicillin-Resistant Staphylococcus Aureus (MRSA), Respiratory Syncytial Virus (RSV), C. Difficile infections).
- Infectious outbreaks are increasing and the ability to manage these requires additional /spare cot capacity to allow cohorting of infected newborn infants without compromising or reducing the clinical service for other newborn infants.

13.4.5 Transport Service

- There needs to be a transport service to enable transfer of emergency and non emergency newborn infants between St Michael's, Southmead, Weston-Super-Mare and the other hospitals within the Western Network.
- This transport service would be available 24 hours per day
- In addition unless the NICU service is located as above (see 13.4.3, first bullet point, then an additional transport service as described in 13.4.3, second bullet point will be required)

13.5 Birth Centres – what is our opinion?

- a. We support the choice that a birth centre gives parents of low risk pregnancies
- b. However
 - i. Admission criteria, delivery and Postnatal care of the newborn infant in a birth centre should be subject to the same rules in terms standard of care, and evidenced based practice, clinical governance etc as the rest of the NHS. This should include input from obstetric and neonatal teams.
 - ii. Birth centres should ideally be adjacent to the provision of specialist Obstetric and Neonatal Care.
 - iii. Parents need to be aware of the potential risks involved in delivering in a birth centre.
 - iv. The staff at a birth centre should have training in resuscitation that complies with National guidance (Resuscitation Council Newborn Life Support Course and similar for Obstetric Care).
 - v. There should be provision for the emergency transfer of mothers and babies from a birth centre to a specialist unit if the situation arises.

Neonatal Nurses

13.6 A number of very positive comments were made regarding the neonatal

services provided at UBHT, in particular the following aspects were noted as particularly good and key to the unit:

- The community team who visit discharged babies.
- The commitment and expertise of the staff.
- The support workers, e.g. ward clerks, housekeeper etc.
- The family support worker.
- The education team.
- The Advanced Neonatal Nurse Practitioners.
- The Transitional Care Unit.
- The Lavender suite

13.7 It was raised that the current services at UBHT are very overstretched, with high expectations and scarce resources. In particular, it was agreed that there was a need for more beds and more staff in order to continue providing high quality services.

13.8 Concern was raised from the UBHT neonatal nurses over the current transfer services provided. It was agreed that there was a need for a dedicated transport team made up of an on-call rota of staff. It was also considered that babies are being transferred too regularly because of the unit often being full, meaning that mothers are often transferred out of the unit to give birth and then back afterwards; this was not considered to be satisfactory.

13.9 It was agreed by the group that there is currently not enough accommodation or parking at the St Michaels unit for family and visitors. In addition, the rest facilities for staff were considered to be inadequate.

13.10 It was noted by the neonatal nurses at UBHT that a larger Transitional Care Unit and a Baby Unit are needed at St Michael's.

13.11 It was agreed that having a NICU service at both NBT and UBHT was of value as it enables both sites to cope with unexpected deliveries. It was also commented that if neonatal services were to be centralised at, UBHT, the centre of Bristol is not a practical site.

13.12 It was noted by the neonatal nurses that the Southmead service would benefit from having more educators, in particular that the nurse educator team needs to expand and there needs to be more education and career progression.

13.13 One group of hospital midwives commented that if neonatal services were centralised at UBHT the unit would then be too big to provide a personal service and that having 2 smaller more *'friendly'* units provides a much higher level of care to women and babies.

13.14 It was noted that it is important to the review to find an agreement across stakeholders, *“so that we can get a consensus agreement”*

14. Miscellaneous Comments

Consultant Obstetricians

14.1 It was noted that a good services is currently being provided by both UBHT and NBT.

14.2 The group suggested that obstetric units should have gynaecological expertise within them or adjacent, as it is often not clear whether an issue is best dealt with by gynaecology or obstetrics. This was noted as particularly important because of the current trend amongst clinicians to specialise in one or the other, it was not clear however, whether this split was of benefit or not.

Community Midwives

14.3 It was suggested by this group that the current service is good at birth, but the level of service on the post-natal wards is less good, women leave the wards quickly and the government targets for breast feeding are unachievable without adequate postnatal support.

14.4 It was noted that Children’s Social Care Trusts and teams across North Somerset would be difficult to implement whilst staff in the North are not employed or managed by the same person, eg, Weston Area Heath who work with North Somerset.

14.5 Professional autonomy was seen as very important to a number of community midwives, being able to exercise clinical judgement being seen as key.

14.6 It was raised by 2 community midwives that there is currently a culture of fear of being subject to litigation within the hospital environment and that this is having a detrimental effect on quality of care.

14.7 One midwife raised that there needs to be a recognition of the role that hormones play in labour, birth and the weeks after birth and that there is a need to provide care in a way which maximises their effectiveness.

14.8 It was noted that root causes of poor outcomes need to be addressed rather the ‘fire fighting’ of recurring problems.

14.9 Having managers within the service that are supporting and provide clear leadership was seen as important to community midwives.

14.10 One community midwife stated that, “*This review offers a genuine opportunity to reconfigure the maternity services, to start from the standpoint of asking, ‘what is needed?’ and to proceed from there*”

Hospital Midwives

14.11 In a meeting of the supervisors of midwives several elements of the current provision of maternity services in the Bristol area were identified as needing improvement, these areas are;

- More defined care pathways between high and low risk.
- Improved quality of postnatal care.
- More midwife led research.
- Strong midwifery influence at the SHA and feedback.

14.12 It was suggested by one group of hospital midwives that more counselling time is needed for debriefing what has happened during birth, people psychological needs need to be met more fully, with better access to mental health services post-natally.

14.13 The confidence that women have in maternity services was viewed as very important. Expectations are rising, but women are often anxious and assume that they are not going to get a good service.

14.14 Post natal care was noted by several groups of hospital midwives as not adequate and that patients are often dissatisfied with the levels of care provided, in particular midwives felt that they were not able to spend enough time with women because of an unrealistic workload. One group of midwives noted that postnatal care does not always need to be provided by a midwife and that staff need to do more skill mix to consider alternatives.

14.15 One group of hospital midwives noted that having a birth unit along side the consultant led unit was a good option as transfer is then very easy, it was also noted that having neonatal services on site was very good. A number of other elements of the services provided at Southmead were highlighted as good practice, these were;

- The Baby Friendly initiative
- Tongue tied service – level 3 – Clinical Negligence Scheme for Trusts (CNST)
- Drug liaison service
- Child protection work
- Smoking cessation support
- Teenage pregnancy liaison
- Birth after thoughts

14.16 It was noted that the status of midwives needs to be raised because of the central role that they play and that there needs to be some recognition that they are doing a good job.

14.17 It was suggested that an Induction Suite and better transitional care was needed.

Other Staff

14.18 It was suggested by a GP practice that midwives might be able to undertake the newborn baby checks and might be able to do their own prescribing i.e. for thrush or mastitis.

14.19 An information and technology worker at a PCT and a public health specialist trainee commented that NICE guidance on antenatal care recommended that early in pregnancy (10-13 weeks women should be offered an ultrasound scan to estimate when your baby is due and to check for multiple births.) It was noted that this services is not currently offered in Bristol and that this does not comply with national standards.

14.20 A public health professional commented that fathers/birth partners need to be involved throughout, from booking to postnatal, if this is what the women would like.

14.21 The public health network stated that smoking cessation and breastfeeding should now be seen as mainstream and not peripheral commissioning requirements.

14.22 It was noted by support staff and health care assistants that all services need to be linked more closely together in one big unit and that any new build would need to be designed sensitively, so that women having abortions or who have lost a baby are not close to postnatal wards.

14.23 It was noted in a general staff meeting that there needs to be consistent input from physiotherapists into parent education classes across BNSSG.

15. Royal College of Midwives

15.1 The following elements of the current services were considered to be good and working well by the members at the meeting;

- Having a birth suite on each site (although it was noted that these units are too close to the consultant-led unit and that staff are routinely required to cover work in the consultant unit).
- The obstetric service, including foetal medicine

- Community midwifery
- Hospital care for high risk women

15.2 The following elements of the current service were noted as being inadequate and in need of change;

- More midwives are needed, regardless of the model of care that is adopted.
- For high risk pregnancies there needs to be some midwife led input (breast feeding information etc) into antenatal care, as currently it is all consultant-led.
- Stronger communication between consultants and community midwives.
- Midwives need to be present at antenatal clinics to provide advice and support.
- Women need to be able to access either high risk or low risk care, depending on what is required, safely and easily.
- There needs to be a choice for midwives as well as mothers, over where they work, how they want to work etc.
- One to one care during delivery is needed and more midwives are needed to achieve this.
- Staff need to be valued and to support each other, with strong midwifery network and teams needed. In particular newly qualified midwifery staff need professional support, using leaders and mentors. There need to be a continual positive learning environment for all new midwives and students.
- There is little continuity of care due to teams in hospitals being too big and there is also a conflict for midwives over their own work/life balance and providing continuity of care for women. In particular antenatal and postnatal continuity of care is not adequate.
- Postnatal care at UBHT is not considered adequate and needs changing; there is currently not enough staff and beds to provide the quality of service needed. It was considered that birth centres would have no limit to the length of stay and therefore women would have more comprehensive postnatal care.
- Concern was raised over the levels of pay and the banding given to midwives.
- 12 week dating scans need to be reintroduced.

15.3 It was agreed in the meeting of the Royal College of Midwives that, *“this review is a new process, and will have the ability to fund new models of care”*. There was, however, concern stated over the direction that maternity services could be taken as a result of the review and concern over what the ‘*new models of care*’ might look like. It was stated, in particular, that it is key that the review does not lead to a, *“repeat of Gloucestershire”*.

16. Validation of Objectives

16.1 Promote normal childbirth

This objective is fully validated by the feedback received from a number of staff groups. It was widely considered that levels of medical interventions are too high and that 'normal childbirth' needs to be promoted and put in to practice more widely. In addition, a number of suggestions have been made in this report as to how this objective may be achieved.

16.2 Promote choices for where, and how, mothers give birth

This objective is largely validated by the feedback received from staff groups. A number of comments were made by staff that there is some level of choice currently offered to women, both as to where they can give birth and who their lead practitioner is. There was also feedback however, suggesting that because of low staff levels, the choices offered (particularly home births and births in the midwife-led birth unit) can not always be provided. It was also fed back from staff members that it is important to women to have the choice of giving birth in a local unit, close to their home.

16.3 Provide safe and effective care to national standards

This objective is validated by the feedback from staff. Providing safe and effective care for mothers and babies was viewed as fundamental to all of the services provided. Concern was voiced that due to low staffing levels at poor facilities, the safety and effectiveness of care was at times compromised and this was viewed as fully inadequate. It was also noted that staffing levels, some elements of the neonatal services and the lack of certain tests being offered, does not comply with national standards.

16.4 Reduce inequalities

This objective has been partly validated by the feedback from staff groups. Concern was raised that services are not being adequately tailored to include certain vulnerable groups. It was noted that the work being done on increasing rates of breastfeeding and reducing smoking rates designed to help reduce inequalities was being effective, but beyond this there was little evidence that there was much being done within the current maternity services to reduce inequalities.

16.5 Make best use of resources, ensuring that services are Affordable

This objective is fully validated by the feedback provided from all staff groups. In particular, the current provision of maternity services are considered

to be under-resourced and in particular significant concern was raised over the understaffing of midwives as a group and the impact that this was having on staff and their ability to provide care. Little concern was given by staff as to whether the services needed would be affordable, but it was acknowledged that there needs to be an increase in skill mix to utilise the skills of existing staff more fully and that only options that can be delivered from a workforce perspective be considered as viable.

16.6 Attract and retain staff by offering good experience and opportunities for development

This objective is fully validated by the feedback given by staff and in particular provided by the community and hospital midwives. The number of midwives being attracted into the profession was seen as a significant concern as was the rate at which midwives are currently leaving the profession. It was felt that low morale was being caused by low staffing, a lack of recognition of key role in the service, poor relationships with other professionals and the erosion of 'normal birth' by an increase in medical interventions. Some issues were also raised over the training and development of midwives and junior doctors and the development of other roles such as midwife assistants.

17. Conclusion

17.1 Generally, staff members from all groups expressed pride and satisfaction in the services that they provide for women and babies, whether it be in the community, in an acute setting or elsewhere. The neonatal services provided at NBT and UBHT were generally considered to be providing a very good service, as were the midwife-led units at UBHT and NBT. There were however, some significant concerns raised from all groups of staff. The main concerns were;

- The high levels of medical intervention and the reduction in the rates of 'normal birth'.
- The lack of genuine choice for women and the poor provision of local facilities close to home.
- The need for more midwives both within the community and the acute setting and the need for greater sharing of knowledge and the strengthening of relationships between professional groups.
- Poor access and parking at UBHT.
- Inadequate postnatal care.
- The lack of services designed to improve access and outcomes for vulnerable groups.
- That the lack of adequate resources is impacting upon staff member's ability to provide high quality care for mothers and babies.

- That the current neonatal services at UBHT and NBT are not meeting a number of national standards.

Sarah Nadin
Bristol PCT
May 2007

Appendix 1. Details of meeting held and attendance

Date	Staff Group	Organisation	Venue	No.
26 Jan 2007	Unit midwives	NBT	Midwifery meetings rooms, Southmead Hospital	22
02 Feb 2007	General support staff	UBHT	Midwifery meetings rooms, Southmead Hospital	3
06 Feb 2007	Consultant obstetricians	NBT	Cotswold seminar room	8
09 Feb 2007	Consultant obstetricians	UBHT	Meeting room, level C, St Michael's Hospital	10
13 Feb 2007	RCM joint meeting	UBHT / WHAT / NBT	Meeting room, level C, St Michael's Hospital	22
14 Feb 2007	Ashcome Unit staff	WAHT	Ashcombe Ward, WGH	8
15 Feb 2007	Neonatal Nurses	NBT	Neonatal Seminar Room, Southmead Hospital	7
20 Feb 2007	Joint consultant neonatologists	NBT	Meeting room, level C, St Michael's Hospital	5
01 Mar 2007	Hospital midwives	UBHT	Meeting room, level C, St Michael's Hospital	7
06 Mar 2007	Hospital midwives	UBHT	Meeting room, level C, St Michael's Hospital	12
06 Mar 2007	Community midwives	UBHT	Meeting room, level C, St Michael's Hospital	15
13 Mar 2007	General Staff	UBHT	Meeting room, level C, St Michael's Hospital	13
13 Mar 2007	Supervisors of midwives	UBHT / WHAT / NBT	Meeting room, level C, St Michael's Hospital	6
21 Mar 2007	Neonatal Nurses	NBT	NICU Seminar Room	10
28 Mar 2007	Neonatal Nurses	UBHT	Gynae seminar room, St Michael's Hospital	7
04 April 2007	Public Health Network Meeting	SGPCT / NSPCT / BPCT	Conference Room 1, KSH	10