Royal College of Midwives

The Royal College of Midwives' response to North Central London ICS consultation *Start Well: Proposed changes to maternity, neonatal, and children's surgical services.*

Introduction

The Royal College of Midwives (RCM) is the trade union and professional organisation that represents most midwives and maternity support workers (MSWs) in the north central London catchment area. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives and MSWs. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

The RCM welcomes the opportunity to respond to this consultation and our comments, set out below, reflect the views of local RCM members, representatives and officers and address the proposals relating to maternity and neonatal services.

The RCM supports retaining maternity and neonatal services at all the current sites provided by North Middlesex University Hospital NHS Trust, Royal Free London NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and Whittington Health NHS Trust. Accordingly, the RCM does not support either the preferred option of removing maternity and neonatal services from the Royal Free Hospital, or the alternative proposal to remove these services from the Whittington Hospital. Furthermore, the RCM advocates retaining facilities to enable women to continue to give birth at the Edgware Birth Centre, albeit with some modification to the way in which it is staffed.

Closing maternity and neonatal services at the Royal Free would have particularly adverse impacts for women with the highest risk pregnancies and with pre-existing medical conditions and on women and families from the most socially deprived areas. The recent MBRRACE report on maternal mortality in the UK suggests that

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many deaths could have been avoided with early referral and management by a multi-disciplinary team with experience of treating women with medical disorders in pregnancy.

The Whittington Hospital provides well managed, highly regarded and very busy maternity and neonatal services for a diverse local population, including some of the most deprived communities in north London. While the consultation document attempts to rationalise the preferred option of closing maternity and neonatal services at the Royal Free (albeit that the arguments are flawed for the reasons we outline below) the consultation makes no serious attempt to explain why services should close at the Whittington.

The RCM is not arguing for a continuation of the status quo:

- We recognise that maternity and neonatal services in north central London face several challenges that have implications for the location of services and deployment of staff.
- We agree that neonatal care should be organised in accordance with British Association of Perinatal Medicine (BAPM) standards and, accordingly, that all neonatal units in NCL should be at least an NLU level 2.
- We also agree that there should be alignment between the obstetric and neonatal services in NCL.

Where we disagree with the consultation is that, rather than proposing the closure of the neonatal unit at the Royal Free, we believe that the interests of women and families would be best served by upgrading the neonatal unit there to a level 2 NLU.

Impact on women and families

The RCM strongly believes that any proposals to reconfigure maternity and neonatal services must weigh considerations of safety, standards and staffing with the impact on women and families. Decisions about moving services should not be taken lightly, especially where these effectively remove choice from women who require or want access to consultant-led care in their locality, in addition to issues around distance, journey time, the quality of roads and transport and the costs of travelling further afield for services.

The patient flow modelling methods used to support the options appraisal are, in our view, over-reliant on the assumption that women and families who would otherwise have been cared for by the unit that closes, will automatically opt for the next nearest unit to them. While there is no doubt that this will be true in many cases, past experience of maternity and neonatal consultations suggest that this will not be the sole consideration for women and families. Other factors, including CQC ratings and other indicators, word of mouth, parking facilities, media coverage are also likely to be measured alongside proximity.

This makes it difficult to predict patient flow with any certainty or to accurately predict the impact on the capacity of neighbouring units and on factors such as level of consultant presence or midwifery staffing establishments. What we do know is that unlike other health services, maternity care cannot be rationed or restricted. The

number of women requiring maternity care and babies needing neonatal care will not be reduced by these proposals but will be reliant on the remaining sites in NCL absorbing the workload from either the Royal Free of Whittington hospitals. Many maternity staff in NCL will remember that the closure of maternity services at Chase Farm Hospital in Enfield was underpinned by patient flow modelling that proved to be inaccurate and which led to significant pressure on the capacity of neighbouring units, including emergency suspension of services on occasion, thereby placing vulnerable women at risk.

Irrespective of whether the services that close are at the Royal Free or Whittington, the proposed reconfiguration of maternity and neonatal services will transfer economic (fares, parking fees) and social (time, childminding arrangements) costs to women and their families. Depending on where women live and which unit they choose to access, the proposed changes will add significant travel times and costs, especially if they rely on public transport. This of course assumes that women will be travelling at times when public transport is running, when the reality is that a woman could equally need to travel during the early hours. Even during normal hours, travelling during the rush hour or school run, or when routes are affected by road works, can add significant additional time onto journeys.

Using TfL journey planner and AA route planner tools and, applying these to a selection of addresses within the catchment areas for the Royal Free and Whittington hospitals, the RCM has undertaken its own analysis of the impact on travel times of closing maternity and neonatal services from either the Royal Free or the Whittington Hospital (appendix one). Compared to the average additional travel times presented in the pre-consultation business case, our analysis suggests that there would be a greater difference in average travel times between the time to the current closest unit and the time to the next closest unit when using public transport. While our analysis indicated a slightly lower additional travel time by car to the Whittington (for women living within the Royal Free catchment area), was slightly less than in the pre-consultation business case, there was a much bigger difference in the additional time taken to travel to the Royal Free for women from addresses within the Whittington Hospital catchment area.

- The average travel time by public transport for addresses in the Royal Free area to the Royal Free was 22 minutes and to the Whittington (the next nearest unit) was 32 minutes, a difference of 10 minutes.
- For addresses in the Royal Free area, the average distance to the Royal Free was 1.8 miles, taking an average of 11 minutes. Driving to the Whittington resulted in an average of 3.4 miles and an average time of 15 minutes.
- The average travel time by public transport for addresses in the Whittington area to the Whittington Hospital was 21 minutes and to the Royal Free (the next nearest unit) was 34 minutes, a difference of 13 minutes.
- For addresses in the Whittington area, the average distance to the Whittington was 1.8 miles, taking an average of 10 minutes. Driving to the Royal Free resulted in an average of 3.6 miles and an average time of 20 minutes.

We have already stated our reservations about patient flow modelling that over-relies on the assumption that women and families will always travel to the next nearest maternity and neonatal unit. Accordingly, we have also calculated average travel times to the other units within NCL as well as to St Mary's and Northwick Park hospitals, for women living within the Royal Free catchment area and to Homerton Hospital, for women living in the Whittington Hospital catchment areas:

- Average additional public transport travelling times for women in the Royal Free catchment area, range from 14 minutes to UCLH to 52 minutes to the North Middlesex Hospital.
- Average additional car mileages and travel times for women in the Royal Free catchment area, range from 1.8 miles and seven minutes to UCLH to 8.7 miles and 19 minutes to Barnet Hospital.
- Average additional public transport travelling times for women in the Whittington catchment area, range from 4 minutes to UCLH to 30 minutes to Barnet Hospital.
- Average additional car mileages and travel times for women in the Whittington catchment area, range from 1.9 miles and 10 minutes to UCLH to 8.8 miles and 26 minutes to Barnet Hospital.

The Royal Free Hospital

With regards to the preferred option of closing maternity and neonatal services at the Royal Free Hospital, our main objection is that the consultation is disproportionately weighted towards the provision of neonatal services without due consideration for maternity services, especially in relation to care for women with complex medical disorders and those who become critically ill at the time around birth. This is not to deny that there are issues to address - neonatal services at the Royal Free are underutilised, this is impacting on the capacity of neighbouring neonatal services and there are challenges in adequately staffing the service and ensuring that staff can maintain their skills – but these would best be resolved as part of a strategy that aligns neonatal and maternity services. This is after all the direction of travel of national policy for maternity and neonatal services.

We are particularly disappointed that the consultation has given little or no consideration to the specialist maternal medicine and intrapartum services at the Royal Free, which have been developed over many years, which make a unique contribution to the safe care of women with complex medical needs and which have achieved excellent clinical and neonatal outcomes.

The RCM notes and endorses the letter of 22 January 2024, submitted to Start Well by clinicians from across maternity care staff groups at the Royal Free hospital (appendix two). The letter outlines the many aspects of maternity care provision at the Royal Free, and particularly the establishment, over 30 years, of high-quality services for critically ill women in maternity, which are often not available to women at other NCL sites. This includes:

- A well-established maternal medicine service with specialist clinics for a wide variety of complex medical conditions.

- A dedicated specialist obstetric anaesthetics clinic and service.
- 24-hour, seven days a week interventional radiology services, and onsite vascular and urology support for critically ill women.
- The second largest Intensive Care Unit in NCL.
- A 24-hour, seven days a week cardiac catheter and coronary care unit, including joint cardiac/obstetric antenatal clinics.
- Onsite specialist kidney and liver physicians and surgeons with associated dialysis and transplant services. This includes joint hepatology/obstetric and renal/obstetric antenatal clinics.
- Specialist pulmonary hypertension service.
- Specialist haemophiliac and bleeding disorder services, with dedicated laboratory and national referral and treatment centres. These services are not available elsewhere within NCL.
- A national amyloidosis centre.
- Specialist rheumatology and neurology services, including joint neurology/obstetric antenatal clinics.
- A specialist HIV antenatal clinic, providing tertiary referral services for one of the largest cohorts of HIV+ women in London. Most pregnant women with HIV who attend the antenatal clinic there are already under the care of the HIV unit at the Royal Free.

While the overall birth rate is currently decreasing, the consultation itself acknowledges that maternity and neonatal services in NCL are caring for increasing numbers of women and babies with complex medical and social needs; the overall volume of work is therefore not decreasing. Data indicates significant levels of deprivation amongst women using the Royal Free hospital.

The Royal Free currently accepts, on a regular basis, women from neighbouring units, including those outside of the NCL catchment area, on the grounds of clinical need or when those units exceed capacity. It is therefore clear that the proposed changes will have a significant impact on the care of women, not just in the Royal Free locality but also in a much wider area, including outside of NCL. In our view, large scale reconfigurations should be organised to minimise the potential transfer between units for women with complex conditions or once they are critically ill.

The pre-consultation business case repeatedly references the Ockenden Review of maternity services at Shrewsbury and Telford Hospital[1] and sets out a vision in which maternity and neonatal care would meet the best practice recommendations in Ockenden. The RCM supports the implementation of the recommendations in Ockenden, including that:

- Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.

[1] Ockenden review: summary of findings, conclusions and essential actions - GOV.UK (www.gov.uk)

- Trusts have in place specialist antenatal clinics dedicated to accommodating women with multifetal pregnancies. They have a dedicated consultant and have dedicated specialist midwifery staffing.
- NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.
- Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment.
- The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.

It should also be noted that the interim Ockenden Report[2] also recommended that there must be robust pathways in place for managing women with complex pregnancies, including:

- Ensuring that women with complex pregnancies have a named consultant lead.
- Agreeing early specialist involvement and management plans between the woman and the team.
- The development of maternal medicine specialist centres as a regional hub and spoke model as an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.

We find it difficult to understand how closing maternity care at the Royal Free, with its years of expertise in caring for women with complex care needs, can be reconciled with implementing these essential actions from the Ockenden Review.

On the other hand, retaining maternity services at the Royal Free and Upgrading neonatal to level 2 would:

- Make it easier to recruit staff into the neonatal unit.
- Increase capacity to care for babies requiring urgent and specialist care and, at the same time, reduce the pressure on neighbouring neonatal services.
- Provide enhanced opportunities for neonatal staff to acquire requisite skills.
- Increase the number of women who would choose to access pregnancy, birth and postnatal care at the Royal Free.

The Edgware Birth Centre

Edgware Birth Centre has provided care and support to women and families over many years, as well as providing a base for community midwives who provide a home birth service on behalf of the Royal Free Hospital NHS Foundation Trust.

[2] OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (donnaockenden.com)

Following an inspection in October 2023, Edgware Birth Centre was rated by CQC[3] as providing a good service, with inspectors commending the "safe care from well-trained staff who worked well and were supported by capable leaders". The report also noted that learning was shared with staff to ensure patient safety.

It is therefore disappointing that Start Well proposes to remove the facility for women to give birth at the Edgware Birth Centre. Although use of the Birth Centre has fallen in recent years, with only around 50 births a year in the last three years, this is partly due to it having to close regularly to provide cover for acute services and staffing shortages in the community. While there have been challenges in staffing the Birth Centre in recent years, current staffing levels are good.

We believe there is a good case for retaining birthing facilities, not least because the consultation recommends retaining antenatal and postnatal services on site. The consultation also repeatedly refers to facilitating patient choice, which is after all a central tenet of national policy for maternity and neonatal services. It is difficult to see how closing birthing facilities at the only standalone birth centre in north London can be reconciled with enhancing choice.

The consultation document argues that it is currently difficult to staff the birth centre and that it would be difficult to reliably ensure that it will always be available for deliveries. We would argue that with the right approach to staffing, it will be possible to assure the sustainability of services at the Edgware Birth Centre, including intrapartum care. Consideration could be given, for example, to moving to staffing model in which the birth centre is staffed by maternity support workers, supported by midwives who are available on-call and who could accompany women to the birth centre when the time has come for them to give birth. This in our view would be preferable to closing Edgware to births and would also ensure continuity of carer for women receiving their antenatal and postnatal care there. Since one of the stated aims of this consultation is to provide women with more continuity of care, retaining birthing facilities at the Edgware Birth Centre would also enhance continuity of care for women who receive their antenatal and postnatal care there. Closing birthing facilities at the only standalone birth centre in north London would in any case be detrimental.

The Whittington Hospital

The RCM is far from persuaded that there are any grounds for including the Whittington Hospital in this consultation. We are as opposed to the proposal to move maternity and neonatal services from the Whittington Hospital as we are to closing maternity and neonatal services at the Royal Free Hospital.

We cannot discern anywhere in the consultation document or pre-consultation business case, any cogent arguments for proposing the removal of maternity and neonatal services from the Whittington Hospital.

Given the significant activity levels at the Whittington (3,400 births and 530 neonatal admissions), and the demography of the population it serves (including areas with

[3] RALRA Edgware Community Hospital (cqc.org.uk)

high levels of deprivation), the consequences of closing maternity and neonatal services, for women and families in Islington and for neighbouring units cannot be overstated.

While the consultation document refers to the most recent CQC inspection[4] as rating maternity services at the Whittington as 'requires improvement,' this overlooks the very many positive findings mentioned by CQC inspectors, including that:

- The service had enough midwifery and medical staff, with the right qualifications, skills, training and experience to keep women safe from avoidable harm to provide the right care and treatment.
- The service managed safety incidents well: staff recognised and reported incidents and near misses; managers investigated incidents and shared lessons with the team and the wider service; staff apologised when things went wrong and gave women honest and reliable information.
- Leaders understood and managed the priorities and issues the service faced and were visible and approachable to staff.
- There was an open culture in which women could raise concerns without fear and in which staff were focused on their needs.
- There were high levels of staff satisfaction, staff were proud of the organisation and were positive about the department and felt able to speak to leaders about difficult issues and when things went wrong.
- Staff worked within and promoted a culture that placed patient care at the heart of the service.
- Staff were clear about their roles and responsibilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Bearing all this in mind, it would be foolhardy to close or reduce the services currently based at the Whittington.

Affordability

The RCM has been repeatedly told that these proposals are about improving the quality and safety of care and are not driven by financial considerations. Nevertheless, we note that the pre-consultation business case evaluates the preferred option as the most beneficial in terms of being able to offset capital investment costs against cash-releasing benefits. Accordingly, it would be naïve to assume that questions of affordability are not a consideration. We are also under no illusion that our proposal for retaining maternity and neonatal services at all five current providers, including upgrading neonatal services at the Royal Free Hospital, will have financial implications and may be deemed too expensive to deliver.

In this context we think it relevant to draw attention to:

- The letter of 8th November 2023 from NHS England to ICB and Trust Chief Executives[5], which in the context of current financial pressures, calls for

[4] RKEQ4 The Whittington Hospital (cqc.org.uk)
[5] NHS England » Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take

priority to be given to protecting patient safety “including in maternity and neonatal care” while allocating an additional £800m to help with reprioritisation.

- The announcement, as part of the spring 2024 budget, of an additional £35m to invest in improving maternity safety across England[6]. This includes £9m for the rollout of the avoiding brain injury in childbirth (ABC) programme and extra funding for 6,000 midwives to be trained in neonatal resuscitation and for staff to receive specialist training in obstetric medicine. In the words of the Secretary of State for Health, “improving maternity safety is a key cornerstone of our Women’s Health Strategy.”

All ICBs should therefore be reviewing how best to ensure that patient care, including maternity and neonatal care, is prioritised and how best to target the increased investment in maternity safety. This must also include ensuring there is alignment between the provision and operation of maternity and neonatal services. Accordingly, we urge North Central London ICB to use this as an opportunity to rethink the Start Well proposals and recognise the need to invest in optimising maternal and neonatal care at the Royal Free, Whittington, UCLH, Barnet and North Middlesex hospitals.

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[6] £35 million investment to boost maternity safety - GOV.UK (www.gov.uk)