NHS England

North Midlands

Review of Consultant-Led Obstetrics in Stafford

Q&A January 2016

What's the difference between consultant-led obstetrics and midwife-led care?

Midwife-led care is when midwives (not doctors) are responsible for maternity care. This is safe and appropriate when a woman's pregnancy is healthy, straightforward and low risk. Consultant-led obstetric care is when consultant doctors take responsibility for a woman's care. This is usually when there is some risk of complications and extra medical care is needed.

Why were consultant-led services moved from Stafford?

On 15 April 2013 Monitor (now NHS Improvement) made a parliamentary order under the National Health Service Act 2006 to appoint a Trust Special Administrator (TSA) to take control of Mid-Staffordshire NHS Foundation Trust. The TSA replaced the Trust board on 16 April 2013 with a remit to determine the future clinical and financial sustainability of the Trust.

In terms of the sustainability of maternity services, following consultation, the TSA recommended that the consultant-led service at Stafford Hospital (now County Hospital) be decommissioned and a Midwife-Led Unit (MLU) be established there to provide an opportunity for low risk births to be delivered locally. However, the Secretary of State for Health requested (in February 2014) that NHS England review whether consultant-led maternity services could be sustained clinically and financially at County Hospital in a safe way in the future.

What has the review found and what are its recommendations?

The independent review makes a number of recommendations, concluding that it would not be possible to reinstate and safely maintain a financially viable consultant-led obstetric service at County Hospital.

The review's key findings and recommendations state:

- Safe levels of recruitment and retention of staff, in accordance with national recommendations, would be the single most difficult challenge and one which is exacerbated by national shortages of sufficiently skilled and qualified clinical staff.
    - The projected number of births at a County Hospital consultant-led obstetric unit would be too low to provide adequate experience for staff to safely maintain their skills, or for trainees to complete their studies.

- The panel did consider staff rotation between Royal Stoke and County Hospital but the number of vacancies would impact on the ability to ensure each site is able to safely staff a full rota. Moreover, an on-call rota of medical staff across the two sites would be extremely challenging because they have to be dedicated to one hospital site which they can get to quickly to respond to emergencies.

- In a challenging financial climate, the level of investment required without the projected numbers of births to provide anything approaching sufficient income, makes the reinstatement of the service financially unviable. It would require on-site specialisms including midwifery, neonatology, anaesthesia, surgery, imaging and mental health services to manage all aspects of childbirth, including severe complication. It would mean two new operating theatres, a special care baby unit, pathology services and blood banks and equipment, in addition to refurbishment and other infrastructure costs.

- The Freestanding Midwife-led Birth Unit at County Hospital is highlighted in the report as a valuable and important service which offers mothers-to-be and their families a great birthing experience. It also provides real choice in line with NICE guidelines. The report recommends that the unit should be better promoted to increase its use.

Did local people have a chance to share their views on this?

Yes. A public listening event, which was widely publicised, was held on 13 September 2016 at which the panel members listened to local people's views. People who couldn't attend this event but who wanted to comment were also invited to share their views with the panel members by email or by contacting the Review Project Team or Healthwatch Staffordshire. The listening event was one part of the Review Panel's evidence gathering and analysis. The project team also asked the public to share their views via Twitter and promotion within local communities, such as local parishes. The findings from the event were incorporated into the overall review.

How did the review panel reach their conclusions? What did they look at?

The review panel has taken a detailed and exhaustive approach to analysing and evidence-gathering over the last three-months. Their work included:

- extensive community and stakeholder consultation including a public listening event, and consideration of public comments contributed by post and email

- visits to the maternity facilities at County Hospital and the consultant-led obstetric unit at Royal Stoke Hospital, where they also listened to the views of staff members, the senior management teams, patients and their families

- engagement with clinical and educational and training networks

- consideration of recommendations within the 2016 National Maternity Review report 'Better Births' and within the 2013 Trust Special Administrator (TSA) service model

- reviewing facilities and available resource

- analysing the market and workforce.

What happens next?

NHS England expects the commissioners and the Staffordshire Sustainability and Transformation Plan to reflect the recommendations of the independent review panel in the provision of services in the future.

Will NHS England be providing further guidance about this to the Secretary of State?

No. This was an independent review and it is an independent report. NHS England commissioned and coordinated the review but the recommendations are based on an independent analysis and evidence-gathering.

Why has it taken so long for NHS England to launch this review?

NHS England committed to this review at the request of the Secretary of State in 2014. However, to ensure the very best insights could be incorporated into this review, it was decided that the review should start only once the National Maternity Review was published (which happened in February 2016).

What was learnt from the National Maternity Review that this review took into account?

The National Maternity Review recommended that providers and commissioners should come together in local maternity systems all working to common agreed standards and protocols. The National Maternity Review identified seven key priorities to drive improvement and ensure women and babies are safely cared for wherever they live. The review identified the need to work across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

The independent panel considered the priorities and recommendations from the National Maternity Review alongside the recommendations from the TSA, local maternity activity data and intelligence, and feedback from stakeholders and members of the public.

How were the review panel members selected and by whom?

The review panel comprised independent, impartial experts as well as a lay member. NHS England (Midlands and East) approached the Clinical Senate and the National Maternity Review team to identify potential experts who could support the review and who were independent and objective.

****