



SHROPSHIRE WOMEN SPEAK OUT:

DEFENDING RURAL MATERNITY CARE



Bobbie Brown, Gill George, Liz Grayston, Alison Hiles

22nd March 2018

“We have been keeping a close watch on the goings-on in Shropshire and are shocked and disappointed by the poor management over recent years which has simultaneously failed to develop, and actively run down, what were once well-established community midwifery birth services”

Mary Newburn, Executive Manager of Midwifery Unit Network

“Our vision is for more midwifery units, not fewer. They are especially needed in rural areas”

Baroness Julia Cumberlege, Chair of the Better Births national maternity review

“Those moments after she was born felt like hours while all the time I watched her tiny chest rise and fall, and prayed that she would keep breathing. These closures are putting so many lives at risk”

Ally Hiles, Ludlow Mum of Amelie, born without midwife support

“It doesn’t convey any benefit. There are no doctors in those hospitals who will step in and do anything. There are no additional staff who will step in if there’s a problem... I don’t think people realise that’s not the case. They could be giving birth in the supermarket with the same level of safety as in the MLU”

Adam Gornall, Obstetrician and Clinical Director of Maternity, Shrewsbury and Telford Hospital NHS Trust, on Shropshire’s freestanding MLUs

Women are not being heard

Ludlow is a market town in the south west of Shropshire. It has an ‘MLU’ – a Midwife-Led Maternity Unit – as a maternity hub for Ludlow and the surrounding area.

In Ludlow, there have been five ‘Births Before Arrival’, known as ‘BBAs’, since May last year. These are babies born without midwife support, because their mother couldn’t reach maternity care in time, or a midwife fails to arrive in time for a home birth.

Five BBAs in one small town is remarkable; an unprecedented cluster of cases¹. Why did it happen? Ludlow MLU was closed on and off throughout the spring of 2017, for most of June 2017, and completely from 1st July through to 31st December. At the same time, midwife cover for home births was centralised and reduced. Health leaders dismiss the BBAs as just one of those things. The women who endured the pain and fear of an unsupported birth, the women who watched their newborn’s chest rising and falling and prayed that their baby would keep breathing – those women say different.

Now, Ludlow MLU is being closed all over again – closed for two weeks currently, due to close for a month in May, and soon to be closed forever. Ludlow is not alone. There are two other MLUs in rural Shropshire: in the towns of Bridgnorth and Oswestry. They, too, have suffered from repeated temporary closures, and are now to be closed forever. Local maternity units have served Shropshire’s rural women for decades. Suddenly, they have been found to be ‘unsustainable’, both clinically and financially.

¹ BBAs are unusual: around 4 in 1000 births. Five BBAs in around 200 births is exceptional by any standards.

The closure of Shropshire's MLUs is in apparent defiance of national maternity policy, established in a ground-breaking 2016 national maternity review known as 'Better Births'. Better Births is about personalised care and choice, continuity of care and carer, and improved postnatal care. All of these are being diminished, not improved, in current plans. Better Births assumes *more* births taking place in the community – in MLUs and at home. There is, of course, no suggestion in Better Births that MLUs should be closed.

Better Births is also about safety – and that's a good reason for the promotion of MLUs. **For women with low risk pregnancies, the evidence shows very clearly indeed that MLUs are a safer place to give birth. Why, then, are Shropshire's MLUs to be closed down? (Proposed community hub replacements, without birthing facilities, are something very different).**

Can you support us?

We're asking for your help – and we're taking this issue out nationally because we are not being heard in Shropshire. We are sending this report to national maternity leaders, to politicians (particularly women), and to NHS leaders. We will also share it with the media.

We don't believe we can win this fight if it stays in Shropshire. We need some powerful allies.

Please read this document, or at least the Executive Summary. We apologise in advance for its complexities – but please remember that we've lived through them!

If you can raise your voice with us and for us – in the maternity world and the NHS, in Parliament, in the media – we would be eternally grateful.

Bobbie Brown, Save Bridgnorth Maternity Unit campaign

Gill George, Shropshire, Telford and Wrekin Defend Our NHS

Liz Grayston, Save Oswestry Maternity Unit campaign

Alison Hiles, Save Ludlow Maternity Unit campaign

22nd March 2018

Executive Summary

Rurality

Shropshire is a sparsely populated and rural area. The single urban centre of Shrewsbury is home to only around 23% of the population. Public transport is poor or non-existent in most areas, and the road network is also poor. The hidden poverty found in most rural areas exists, unsurprisingly, in Shropshire too. In this context, **access** to healthcare is key. There is a responsibility on public sector decision makers to be mindful of 'rural proofing' services and service changes.

There are three rural Midwife-Led Units, in the towns of Bridgnorth, Ludlow and Oswestry. These act as maternity hubs that serve their surrounding area. These cover the north west, south west and south east area of Shropshire well. The rural north east is less well-served, and maternity campaigners would like to see this addressed.

The rural MLUs face a dual threat: from the hospital trust (SaTH) that runs them, and from Shropshire CCG as the major commissioner of the services.

The history

SaTH

Rural *and* urban MLUs have been marginalised and ignored by SaTH for many years. Two years ago, SaTH decided to close the rural MLUs to save money – but overwhelming public opposition has made this hard for them to push through. Instead, we have seen repeated short term closures, with the transfer of staff to the Obstetric Unit in Telford. The short-term closures culminated in a six month closure from 1st July 2017 to 31st December 2017. Rural women were left without access to a local service. Although the MLUs re-opened on 1st January this year, SaTH immediately began to close them again, and now plans to close them for periods of a month at a time.

Closures have happened with a few hours' notice, causing enormous distress for women and for staff. The reasons given for closure are routinely at odds with the evidence. There has been no consultation with service users. SaTH is also now cutting postnatal care in rural MLUs, by means of taking the mattresses off the beds. Someone somewhere has also decided that Oswestry women giving birth in Wrexham are not allowed to return to Oswestry MLU for inpatient postnatal care. It's been denied – but it's happening.

And the CCG...

There has also been a CCG review of MLUs, led by Shropshire CCG. We have strong concerns with aspects of the process followed by the CCG, and claims of 'co-design' are far-fetched when the voices of so many women have been ignored.

The CCG now proposes a strategy of increasing MLU births by *closing* the rural MLUs. Postnatal care stays will only be at the Obstetric Unit in Telford, far removed from the areas currently covered by the rural MLUs. Postnatal beds will be reduced from 60 to 26. Routine home visits for postnatal care will end. The 24/7 'drop in' antenatal and postnatal support currently available at rural MLUs will be reduced to 12 hours a day, with reduced access to midwife care within that 12 hours. Women will face long journeys to access out of hours' face to face support when it is needed.

Competing narratives – but the same solution

From both organisations, there is an acceptance that it is legitimate to close MLUs, and to use the reduced births resulting from closure as a justification to close them some more. The process taking place now amounts to deliberate and planned destruction of a necessary and valued service.

The Better Births national maternity review should be an important priority for every maternity provider and commissioner. Better Births priorities include personalisation and choice, continuity of care and carer, and improved postnatal care. It is inherent in Better Births that there will be a transfer of care away from Obstetric Units to midwife-led care (to MLUs and home births) – and for women with low risk pregnancies, the evidence is that this care is safer.

SaTH simply ignores Better Births. SaTH remains committed to its current strategy of channelling 85% of women through its Obstetric Unit – whether they want to give birth there or not.

Shropshire CCG has become adept at using the language of Better Births – but for rural women in particular, is proposing to reduce personalisation and choice, and to reduce the continuity of care (and often carer) that exists in our rural MLUs now. Inpatient postnatal care will be reduced sharply and centralised in Telford (reducing access for many women). Local access to antenatal and postnatal care will be reduced from 24 hours a day to 12 hours a day for rural women, with only planned rather than drop in access to midwife-led care within that period. Home visits for care are to be replaced with care from community hubs, again reducing access. And will closing MLUs increase MLU use? It's an interesting approach!

Transfer rates, choice and sustainability

SaTH and the CCG are in agreement that *'The current model is not clinically sustainable. The current staffing levels and skill mix are not appropriate for the demand'*.

Neither is willing to acknowledge the reasons for the low activity levels (not demand) at rural MLUs: that SaTH keeps closing them down, of course; also, importantly, because SaTH's transfer rates are far in excess of national norms. Locally, 44% of women **choose** an MLU birth – but SaTH transfers around two thirds of those women to Telford's Obstetric Unit. More typical rates would be 30 to 40%, for antenatal and intrapartum transfers combined.

SaTH insists that rural women are 'choosing' to use the Obstetric Unit and justifying closure of rural MLUs on that basis – yet our survey shows that **only 2.1% of expectant or recent rural mothers chose an Obstetric Unit birth** themselves. A large number of women are choosing midwife-led care – and they are being denied that choice.

It is surely poor practice to drive down the use of rural MLUs and judge sustainability on the reduced number of births that results. A respect for choice and an implementation of national norms for transfer between MLU and OU settings would readily establish births of around 250 a year at the rural MLUs – absolutely typical of rural MLUs. The wider context would be of rural MLUs within an overall service where 1500 women gave birth in an MLU, rather than the 650 who would typically do so now.

The sums around sustainability immediately change. Clinical sustainability should be a given, in MLUs that are a typical size for rural MLUs, and that are one strand in a thriving service line. And as numbers increase, the cost effectiveness built into midwife-led care will outweigh the overheads of providing the service.

Rural MLUs – like most rural services – are unlikely to achieve the ‘economies of scale’ that are realisable in an urban setting. That is not a good reason for closing them down, when the impact on local women is demonstrably such a damaging one.

[Listening to Women](#)

During the engagement work of the CCG, rural women have been adamant that their MLUs are needed and must remain.

Women say they need to reach their intended place of birth quickly and easily. This is to be ended.

Women say they value being cared for by the same midwife, or one of a team of midwives, through antenatal care, birth and postnatal care. This will go, as rural women are to be *required* to give birth in an unfamiliar setting with staff they do not know.

Women have repeatedly praised the postnatal care available in rural MLUs, and this has been recognised by the CCG as ‘exceptional’. This, too, is to end.

Are women being heard? No. The anger and bitterness of women who having their maternity services taken away from them is immense.

[What do maternity campaigners want?](#)

The objective is clearly one of safe, high quality, accessible care that meets the needs of **all** women, urban and rural alike. The current proposals from the CCGs will deliver worse care, for almost everybody – but in particular, for women in rural areas.

Concretely, immediately and urgently:

- We need SaTH to stop its relentless games playing designed to undermine and close rural MLUs. It is repugnant, creates risk, and is surely unacceptable.
- Shropshire CCG’s proposals have been put into a ‘Pre-Consultation Business Case’, to be considered by the Clinical Senate. We have asked for a copy of that document; as yet, we do not know if the CCG is willing to make it public.
- We welcome the involvement of the Clinical Senate. We have asked Shropshire CCG to consider submitting to the Clinical Senate a paper from maternity campaigners on rural maternity services. The Clinical Senate will only consider wider views if they are submitted by the CCG. The request was made some weeks ago, and there is a local precedent for this. As yet, we do not know if the CCG will agree.

We would also like to see the sparsity of Shropshire recognised in national funding arrangements.

We would welcome your support in lobbying for any of these aims. There is a basic reality here, overlooked by NHS decision makers. Women in rural areas have always needed access to safe and accessible maternity care. Women *still* need that access.

The Chief Executive of SaTH is Simon Wright: simon.wright@sath.nhs.uk

The Accountable Officer of Shropshire CCG is Simon Freeman: simon.freeman1@nhs.net

A recent history of Shropshire's maternity services

Our MLUs face a dual threat. They are run by hospital trust Shrewsbury and Telford Hospital NHS Trust, known as SaTH. SaTH provides care to a vast area of over 2000 square miles, across largely rural Shropshire, the more urban Telford and Wrekin, and also to rural mid-Wales. SaTH believes that it makes a loss on running rural MLUs, and has wanted to close them down for around two years. The level of public opposition to this has been exceptionally high. Petitions against closure or downgrading of the MLUs have been signed by over 8000 people. Many thousands of women have marched and protested, chanting '*What do we want? Babies! Where do we want them? Oswestry!*' (or Ludlow, or Bridgnorth, as occasion demands). It may be a slogan that lacks finesse – but it captures the spirit of defiance very well. The protest movement has been led by local mothers, but has gone far beyond them in its reach.

The Shropshire components of SaTH's services are commissioned by Shropshire Clinical Commissioning Group (CCG). The CCG was told by SaTH that rural MLUs were no longer sustainable, and began a review of MLUs around a year ago. This became a joint review, on behalf of Telford and Wrekin CCG too – although the lead was taken throughout by Shropshire. The proposals from the CCG, announced in November last year, are a little bizarre. The intention is to increase the number of MLU births – and to do this by closing down the MLUs supporting rural areas!

Some detail:

SaTH took a decision in April 2016 to progress the closure of three rural MLUs to save £1.5 million. (The net loss in the MLU service is said to be £1 million). The closure was to be one strand of the wider 'Carter review' of operational efficiency.

Events have taken us through escalating short term closures and through a six month closure from 1st July to 31st December last year. There was no public engagement on these closures, which caused very great distress to women. Campaigners believe that the justification for the closures were spurious. SaTH insisted both that the maternity service was fully staffed and had no difficulties with recruitment – **and** that staff shortages led unavoidably to closure. Similarly, a key report to SaTH's Board reported 'fairly steady' sickness rates at a level below the Trust average – yet unexpected staff sickness was used repeatedly as a key reason for MLU closure. It is a history that created an atmosphere of distrust.

Our account is regarded as 'untrue' by Simon Wright, Chief Executive of SaTH. We have provided him with the detailed evidence that it is not:

<https://shropshiredefendournhs.files.wordpress.com/2018/03/rural-mlu-letter-response-to-simon-wright.pdf> .

Details of more recent events are in our briefing paper 'The Destruction of Care', available here: <https://shropshiredefendournhs.files.wordpress.com/2018/03/the-destruction-of-care.pdf>

The expectation from SaTH was that the CCG's decisions would be agreed and implemented before the six month closure period expired. In the event, the CCG review has been delayed, and now awaits review by a regional NHS body called the Clinical Senate. Our rural MLUs in Bridgnorth, Ludlow and Oswestry therefore re-opened on 1st January 2018.

Within days, SaTH began to reclose the MLUs. The closures affected all three rural MLUs, although Oswestry was initially the main target. Notice periods have typically been a few hours, with midwives also not knowing in advance what is to happen. Women have found out in many cases via Facebook that their planned place of birth is to be closed that evening or the following day. It is a shoddy and disrespectful approach to providing care, unfair to staff and service users alike.

The **planned** 'safe staffing' hours for January – published on SaTH's website - show an *intention* from SaTH that Oswestry would be massively understaffed right from the word go, and would be unable to maintain a consistent overnight service. This is not something that happened through unanticipated staff shortages. SaTH's decision, *before* it re-opened the MLUs, was that it would also be closing them down within a matter of days.

Oswestry MLU has been closed, since 1st January, at the following times:

- 8th January 8pm to 8am
- 26th January, for the weekend
- 30th January, 8pm to 8am
- 7th February 8pm to 8am
- 9th February from 8pm, through to 25th February (antenatal and postnatal appointments available 8am to 8pm)
- An extension of the closure through to 8am on 10th March

SaTH argues that women are voting with their feet and choosing not to use Oswestry MLU. We suggest it is being made very, very difficult for Oswestry women to give birth at their local MLU.

The current closure of Ludlow is likely to be equally planned and intentional. The closures are not about an immediate response to a situation where there is a risk to patient safety – and SaTH no longer claims that they are.

Postnatal care beds in rural MLUs have been lost on a significant scale, by means of taking the mattresses away. Women have been denied care as a result. SaTH denies it; we've spoken to the women. Postnatal beds were also lost at Shrewsbury MLU on 11th December, and have not yet been reinstated. A further sudden policy change on 9th March determined that women who had given birth at Wrexham Maelor Hospital - a common and rational choice for women in the north west of the county needing complex care – would no longer be allowed to return to Oswestry MLU for postnatal care. SaTH attributed this to 'miscommunication' – but it happened again, five days later.

And most recently, less than two weeks ago, we learned that SaTH intends to escalate its rural MLU closures to periods of a month. Ludlow MLU is already closed until 25th March; subsequently, Bridgnorth is scheduled to close from 26th March for a month. The change-over date is an organisational convenience; it represents the start of the new staffing rota. After Bridgnorth has closed for a month, the intention is that it will re-open but Ludlow MLU will close again, for a month. The intention is to continue month long closures of birthing and inpatient postnatal care until CCG review recommendations are implemented. Closures of this length will effectively end the rural MLU service. Women need to have some security and confidence about where they will give birth, not have it turned into a lottery where the odds get progressively longer.

We anticipate that SaTH will deny this. We stand by it. The person who told us was well placed to know, and it has been confirmed elsewhere.

Simon Wright assured us in a letter of 5th March that the maternity service is staffed **above establishment**, for an establishment that was designed to run an Obstetric Unit and the existing network of MLUs. This is a Trust that recruited to over 20 WTE midwife posts last year.

Recent explanations for the closure of rural MLUs are consistent with an intentional policy shift, rather than dealing with urgent operational issues. For example, news releases from SaTH tell us that *'Our mums are choosing to have their babies in our Consultant-led unit over our rural MLUs'* and *'we anticipate women will continue to give birth away from our rural MLUs, and our midwives will need to be where our mums are'*.

Our view is that SaTH repeatedly allows what it would *like* to be happening to interfere with its day to day responsibility to provide a service. The culture is one of engineering a situation where the desired outcome somehow just 'happens'. The combination of cuts and closures is creating a situation where it is very difficult indeed for women to choose to give birth at a rural MLU. The low number of births is then – again and again – used to justify further closures. And the closures themselves are cited by SaTH and Shropshire CCG as evidence that the service is not sustainable.

SaTH has taken us a very long way down the route to creating a *'fait accompli'* that will determine the outcome of the CCG-led review: three rural MLUs that are no longer functioning. It would be a reasonable public and CCG expectation that closing a clinical service is a last resort – especially one of such high priority as a maternity service. An approach of *'We're closing the rural MLUs because this is our preferred direction of travel in policy terms'* is unacceptable.

Competing narratives - but the same solution

SaTH

SaTH's position has become one of complete disregard for Better Births. There is an acceptance – beyond this, an insistence – that ever-increasing numbers of women are 'choosing' to give birth at Telford's Obstetric Unit, and the priority for SaTH is therefore to follow their lead and concentrate staff and resources accordingly. The urban MLUs in Shrewsbury and Telford have not come under sustained attack, but have simply been neglected. The Alongside MLU 'The Wrekin' has been vastly over-shadowed by its shiny, new, and much-advertised Obstetric Unit big sister. The environment at Shrewsbury has been physically neglected, and some women have told us of 'third world conditions'. The Shrewsbury MLU is now in a temporary home following damage caused first by flood and then by snow. Staffing levels at Shrewsbury have historically been at establishment level – but that has left staff working under considerable pressure, and the level of care will at times have reflected this.

MLUs are not SaTH's priority; nor are home births. An increase in the negligible number of home births was described in one report as a 'risk'. The priority is the 'Consultant-Led Unit', the Obstetric Unit at Telford.

Shropshire CCG

The review of Shropshire's MLUs began in March last year, led by Shropshire CCG on behalf of Shropshire and Telford and Wrekin CCGs. The terms of reference included clinical and financial sustainability, in the light of concerns raised by SaTH, and value for money. The CCG-led review has

reached interesting conclusions. The starting point for the senior staff leading the review was an acceptance of SaTH's position that almost all women will give birth in the Consultant-Led Unit, it's a national pattern, and there's nothing we can do or should be doing to counter this.

Maternity campaigners were uncomfortable with this attitude. There were concerns, too, about process. The CCG insisted on appointing its own patient representative, breaking with established protocol of the patient voice coming via the Patient Group. The person they appointed was robustly of the view, and publicly open about that view, that women who live in rural areas just have to accept a lower level of healthcare provision.

The expert midwife advisor used by the CCG, now working in a private consultancy role, had a background of working in Obstetric Unit settings. Her clinical experience was not in MLUs, and she was therefore a surprising choice to advise on a review of MLUs. She, too, publicly supported the view that people in rural areas should not expect to have access to local services, and in one meeting told women that it shouldn't be a problem travelling 30 miles to give birth because they had 9 months to prepare.

The CCG also worked with a Professor of Midwifery, a leading national expert on MLUs. Bizarrely, this expert was given incorrect information by the senior CCG representative leading the review work. Specifically, the brief was, *'The 3 smaller MLUs currently have between around 30-50 births per year and from our perspective aren't sustainable or in line with demand.'* **This, by accident or design, is shockingly inaccurate.** The rural MLUs had 211 births in 2012/13; 211 again in 2013/14; 186 in 2014/15, when a new Obstetric Unit opened to a fanfare of publicity and with extensive promotion; and 216 in 2015/16. The number of births fell to 165 in 2016/17, reflecting the sustained attack on rural MLUs that was, by then, taking place.

It is implied that the 30 to 50 births a year is the total for the three MLUs together, and it is clear from correspondence we have seen that the Professor of Midwifery understood it as such. Even if the MLUs are taken individually, the '30 to 50 births' figure is misleading. The only MLU that has **ever** dipped below 50 births a year is Ludlow, on two occasions in the last decade². The CCG Board was told that this independent expert supported the MLU closures, and the CCG has also put this in writing. Did the CCG deliberately supply misleading data?

The expert concerned has told us, 'I support FMUs [freestanding Midwife-Led Units] unequivocally and numbers of births are not especially relevant if the buildings are being used for other purposes and open for births when required'. We invite the CCG to publicise this.

Lively debates have taken place, in writing, at engagement events and at CCG Governing Body meetings. The engagement events were variable: some feeling open, others extraordinarily 'stitched up'. Women have bitter memories of having to grab the felt tip from the hands of facilitators to ensure that dangerous words like 'access', 'rural' and 'MLU' were written on flip charts. Midwives from rural MLUs told us that they were uncomfortable in speaking out, because the SaTH Head of Midwifery was present at almost every event, and was a voluble proponent of a very different perspective to their

² The use of Ludlow MLU has been affected on a long term basis by SaTH's reluctance to take responsibility for the avoidable death in 2009 of a baby in their care. The parents of that little girl battled for many years to establish the truth of what happened to their daughter, and their fight has attracted a high level of local and national media attention. The circumstances of this desperately tragic case will undoubtedly feature again when a current NHS England review into the safety of SaTH's maternity services makes its report.

own. And ultimately 'co-design' becomes meaningless if the views of countless rural women can be disregarded apparently on the basis that one participant said in one workshop, 'No, close them down'.

Nevertheless, the formal position has shifted to one of recognising Better Births priorities, including personalised care, continuity of care, safer care, better postnatal care, working across boundaries, and establishing a fair payment system. The language in which the review report is couched cannot be faulted.

The devil lies in the detail. The CCG's objectives are, on the face of it, very different to SaTH's – but the organisational priorities are similar. **The CCG's belief is that it will increase the number of MLU births by closing the rural MLUs. We do not find this credible at all.** Continuity of care and carer does not feature at all in the proposals of the review report – and the existing continuity of care that exists for women using the rural MLUs will be ended. The CCG's proposals are seemingly at odds with the objectives within a new 'Local Maternity System' plan for maternity, published this month.

The number of postnatal beds is to be reduced from 60 to 26 overall, all to be based at the Obstetric Unit at Telford (a very long way from most of rural Shropshire). The current protocol is that every woman receives at least two home visits postnatally, in addition to care as required at MLUs; this is to be replaced by postnatal care delivered at new community hubs. Currently, local face to face postnatal care is available on a telephone or drop in basis at MLUs 24 hours a day. In the proposed model, for rural areas, this will be replaced by 12 hour a day *planned* midwife-led care at community hubs. A 24/7 phone line is intended to fill the gaps. Women requiring out of hours postnatal (or antenatal) care from a midwife will face lengthy journeys currently to Telford, or to Shrewsbury if the service is ever restarted. We do not believe that these measures are likely to improve postnatal care.

And staffing will be reduced: from the current 252 midwife shifts and 98 MSW shifts each week down to as few as 225 midwife shifts and 71 MSW shifts. It seems unlikely to us that personalised care will arise from a reduction in support from both midwives and Maternity Support Workers. The objective here is surely one of cutting costs.

There are certainly positive strands in the CCG's proposals: the ability to decide on place of birth later in pregnancy, which campaigners have lobbied for; community hubs to include wider lifestyle services such as smoking cessation and weight management; a standardisation of services to ensure that all hubs offer antenatal scanning, and planned appointments where required with an obstetrician. These things are welcome, and could and should be integrated with the existing MLU model. The positive elements do not outweigh the major negative consequences for rural women of losing local birthing facilities, local inpatient postnatal care, and local out of hours support.

Activity versus demand

SaTH and the CCG have used an April 2017 Birthrate Plus evaluation, a well-respected tool for calculating staffing levels, as a strong argument for closing the rural MLUs. The conclusion of the Birthrate Plus review was that the rural MLUs were over-staffed for their level of activity.

That is correct – and becomes more correct at each successive closure, and with each woman who decides that the benefits of a local MLU birth are outweighed by fear that it will turn out to be unavailable at the time it is needed.

There are two possible responses to rural MLUs being over-staffed for their level of activity. One is to get rid of the rural MLUs. The other is to explore the possibility of *increasing* the level of activity in line with the really solid evidence on demand. It is really regrettable that both SaTH and the CCG have failed to even consider this.

The CCG's Executive Summary includes the conclusion '*The current model is not clinically sustainable. The current staffing levels and skill mix are not appropriate for the demand*'. It is a flawed conclusion, based not on **demand**, but on a level of activity that has been driven down by the service provider.

The demise of normality in childbirth?³

The low birth numbers at all Shropshire's MLUs, urban and rural alike, reflect a policy within SaTH of transferring an unusually high percentage of women **from** the MLU birth they have chosen to the Obstetric Unit birth they have **not** chosen. It's an approach that puts women at risk. The landmark Birthplace Study established that for low risk pregnancies, an MLU birth is as safe for the baby, safer for the mother, and more cost effective for the NHS.

Data from the CCG review and SaTH highlight the extent of the problem.

- **In 2015 and 2016, 44% of women chose an MLU or home birth (3921 women overwhelmingly choosing an MLU birth).**
- **Of those women, 43% were transferred to Obstetric Unit care antenatally. This means 1700 women chose to give birth in an MLU, but were unable to do so.**
- **Research suggests that 22 to 24%⁴ is an appropriate antenatal transfer figure; why then is SaTH's figure so high?**
- **At SaTH, intrapartum transfer rates are also high. Of the 2221 women remaining, 33% transferred during labour to give birth at the Obstetric Unit.**
- **The largescale Birthplace Study established an overall intrapartum transfer rate of around 20% overall (higher for first births and lower for subsequent births). Again, SaTH's figures are out of step with national norms.**
- **In 2015 and 2016 together, 1498 women had a midwife-led birth in SaTH's care. If typical and clinically appropriate transfer rates had applied, there would have been 2415 women. This is a conservative estimate.**

We stress we are not advocating putting any woman or any baby at risk. The safety of women and babies is of paramount importance. However, requiring women to have an Obstetric Unit birth when they don't need or want one *does* put women at risk. By denying choice, and by over-medicalising straightforward low risk births, SaTH is creating *additional* risks. Safety of MLUs can be promoted through honest and informed decision making; clinically driven risk assessment; robust operational policies that are regularly reviewed; commissioning of effective ambulance transfer when required; and of course mandatory training for midwives to ensure confidence and competence if an emergency situation does arise.

³ The phrase was used by Begley et al in the 2010 MIDU study

⁴ 24% in the MIDU study's careful analysis of Irish data; 22% and 23% cited by UK expert Denis Walsh in his 2017 lecture to SaTH's Rural Midwifery conference

Choice?

SaTH continues to insist that women are choosing to use the Obstetric Unit.

SaTH's own data show that 44% of women choose midwife-led care, with an MLU or home birth. Only 15% of women succeed. This is a service where 85% of women give birth in the Obstetric Unit. It is time to drop the pretence that choice is meaningful in Shropshire, Telford and Wrekin.

Maternity campaigners have recently surveyed 520 women who live in the Bridgnorth, Ludlow or Oswestry area, and who are either currently pregnant or who have given birth since 1st April 2016. We asked them about choice. **Only 2.1% of those women had *chosen* the Obstetric Unit as their preferred place of birth – but 54% of them were *told* they had to use the Obstetric Unit. This is not a picture of women choosing to use the Obstetric Unit.**

Numbers – and sustainability

The current expert recommendation to our local CCGs is that an overall 30% of local births taking place in MLUs is an achievable figure in the medium term, with 35% an appropriate aspiration⁵. This would translate into 1500 to 1750 MLU births a year. These are evidence based figures. The lower figure of 1500 is regarded, by one of the UK's leading experts, as realistic and achievable in the medium term.

Currently in Shropshire, Telford and Wrekin, around 650 women a year give birth either in a rural MLU or in the urban MLUs at Shrewsbury and Telford. Instead, around 1500 could and should be doing so. This would be a safer service for women, and a more cost effective service for our local NHS. All of our MLUs are under-used, urban and rural.

Any case on clinical or financial sustainability must look at the service as a whole. Good practice in the provision of healthcare is '*Local where you can, central where you must*'. Clinically, there is a demonstrable need for rural MLUs – because rural women are telling the CCG and SaTH they do NOT want to use the Obstetric Unit, longer journeys in labour are associated with BBAs and the increased risk that goes with those (and of course with pain and fear), and women in the Ludlow area - the greatest distance of the rural patches from the Obstetric Unit - are ending up giving birth without midwife support in numbers that are completely unacceptable.

The likely numbers for the rural MLUs? They will always be small MLUs, because they serve small rural populations. Nationally, 37% of freestanding MLUs have fewer than 100 births a year, with 57% having fewer than 200 births a year⁶. Rural MLUs are most likely to be the small ones.

We know from SaTH that 788 women chose a rural MLU birth in 2015 and 2016 together. Applying typical and clinically appropriate transfer rates, rather than SaTH's transfer rates, translates into a likely range of 243 to 280 births a year for the rural MLUs combined⁷. This is a very robust and reasonable starting point.

There are other data available. SaTH data obtained from the CCG shows that 680 women had one of the rural MLUs as their closest maternity unit (2016/17). Applying that expert guidance shows a range

⁵ Denis Walsh, Associate Professor of Midwifery, correspondence with Fiona Ellis, November 2017

⁶ Denis Walsh, 2017 presentation to SaTH conference on Implementing the National Maternity Review in Rural Areas

⁷ The lower estimate uses Begley's 23% for antenatal transfer and the Birthplace Study 20% for postnatal transfer; the higher estimate is from the 2013 RCOG 'less than 30%' for the two combined

of 204 to 238 births a year, with 204 achievable in the medium term. However, the 2013 CCG review identified an annual number of 882 births in the areas of Bridgnorth, Ludlow and Oswestry. This would lead us to between 300 and 315 births a year. We also know from 2016/17 data that over 11% of rural MLU users are choosing to travel because they prefer the model of care offered by rural MLUs. This would lead us to a range between 238 births and 350 births a year.

This can feel a bit like pick a number, any number, but – from SaTH’s data, for rural MLUs that were at the time being run down and undermined – annual births of around 250 should have been readily achievable across the rural MLUs combined. Reaching this figure, itself at the most conservative end of evidence based estimates, simply requires a combination of respecting choice and implementing nationally established transfer rates. This is achievable next year – if our CCGs choose to make decisions in line with Better Births recommendations. With promotion of the service, there should be scope for an increase to upwards of 300 births a year in the future. These will always be small MLUs – but that makes them absolutely *typical* of rural MLUs.

Antenatal and Postnatal Care

The MLUs, urban and rural, are not just about supporting low risk births. MLU midwives also undertake all antenatal bookings; provide both high and low risk antenatal care for the Obstetric Unit; and deliver the community-based antenatal and postnatal service. They already operate to a very great extent as community hubs, offering flexible support to women who need it.

The report from the CCG-led review notes that the rural community midwife teams regularly offer 300 to 400 antenatal appointments a month. This is almost certainly an underestimate. A SaTH Freedom of Information response shows 10,588 antenatal appointments from Bridgnorth, Ludlow and Oswestry MLUs in the year 2015/16.

In 2016/17, the rural MLUs offered inpatient postnatal care to 337 women who had given birth at the Obstetric Unit, as well as care – when needed – to women who had given birth at the MLU. The total number of bed days used for postnatal care was 1130 across the rural MLUs. And midwives also gave post-discharge postnatal care to around 680 women: a home visit the day after MLU or hospital discharge, a visit five days after going home, and additional care (including 24/7 phone or drop in support) where that was needed.

These are busy units. It is disgraceful that SaTH has created a myth (and allowed derogatory and divisive language to be used about its own staff) that rural midwives ‘sit about twiddling their thumbs’ while their Obstetric Unit colleagues are rushed off their feet. These are different jobs, all our maternity units need proper staffing, and SaTH’s recruitment of additional midwives for the Obstetric Unit is long, long overdue – but none of our midwives sits about twiddling their thumbs.

Are the MLUs sustainable?

Is it clinically sustainable to have three MLUs offering 250 births between them, with antenatal and postnatal care for around 700 women a year? There’s no reason at all why it shouldn’t be. This is what rural MLUs look like.

And on financial sustainability, neither SaTH nor our CCGs have acknowledged the Birthplace Cost-effectiveness study, nor the NICE guidance on maternity costs. At 2011 prices, each birth in a Freestanding MLU costs £130 less than an Obstetric Unit birth (in addition to being safer for women). Units that are difficult to justify on the basis of the handful of women who battle their way

through inappropriate transfer and repeated closures – well, let’s do the sums again on the basis of thriving units with 250 women giving birth and 700 women receiving antenatal and postnatal care.

Do the sums, too, in the context of an overall MLU service with twice the number of births overall, a service that could be utterly transformed - not by closing the rural MLUs but by listening to why women value that model of care so passionately.

And on financial sustainability, big numbers are being thrown around by SaTH – and the CCG seems to have unquestioningly accepted them. SaTH’s maternity service is £7 million a year in deficit, we are told. Behind that figure, though, the MLU service loses around £1 million a year. Allowing women to give birth in MLUs will change the £1 million. The biggest overhead is the £5.8 million CNST payment, the Trust’s ‘insurance premium’ for its maternity care. This *is* large, and the history of SaTH’s maternity service explains why it is large. We are waiting, of course, for the outcome of the review into safety ordered last year by the Secretary of State for Health, following a string of avoidable deaths. The solution to achieving cost savings here cannot be to scabble around for savings that penalise rural women. The solution must be to tackle head on the safety problems that are reflected in that £5.8 million overhead.

Sustainability in 2013

In 2013, Shropshire CCG had a very different strategy.

A Shropshire CCG-led review (on behalf of Shropshire and Telford and Wrekin CCGs) concluded that only 25% of ‘low risk’ women gave birth in MLUs, despite this being the safest option for them. The CCG conclusion was that the high costs per MLU birth in Shropshire was due to their under-utilisation, and that increasing the number of births in MLUs and maximising capacity in MLUs would reduce the cost per birth. It was an evidence based analysis, using the cost effectiveness data from the reputable ‘Birthplace’ work. The CCG recommendation to SaTH was to work with commissioners to promote and increase the percentage of deliveries in MLUs.

Nobody bothered. Shropshire CCG has undergone multiple changes of leadership over several years, and is currently under ‘legal direction’. SaTH’s maternity service has been deeply troubled. In the general turmoil, a strategic direction for maternity, based on good practice, was completely lost. The recommendation vanished without trace.

Now, the informed analysis of 2013 has been replaced by something much cruder: a variant on ‘*Not many births, not sustainable, close them down*’. The words ‘sustainable’ and ‘sustainability’ have been used loosely, but the main evidence for a lack of sustainability of rural MLUs has been firstly, the lower activity rates in 2016/17, and secondly, that SaTH has repeatedly closed them down. The CCG conclusion in 2017/18 is ‘*A new service model is proposed that seeks to improve clinical and financial sustainability*’ – a conclusion that is exactly the same as its starting point.

This is a perverse conclusion.

- It is not evidence based
- It denies women choice
- It penalises women in rural areas, with no acknowledgement of the need for rural proofing
- It results in worse postnatal care, potentially for all women giving birth in Shropshire, Telford and Wrekin

- It reinforces the ongoing over-dependence on the Obstetric Unit – with the increased costs and the worse outcomes for ‘low risk’ women that follow this
- The increased pressure on Obstetric Unit resources results in worse care for women with more complex needs who require that specialist care. Put simply, scarce resources are being spread too thin.

We know that SaTH has no commitment to its community midwifery and MLU service. We know that SaTH regards an increase in home births as a ‘risk’, and that cover for home births has been reduced. If SaTH is not able to support these service strands, the CCG should seek an alternative NHS provider. There are two nearby Trusts (Powys and Sandwell and West Birmingham) that have supported midwife-led care far more strongly than SaTH.

Listening to women

Numbers are a part of the future – but only a part. Women now want to be heard.

Rural women went to every possible CCG engagement session and ‘co-design workshop’. The message from these women was that rural MLUs are essential and must stay. Any future without rural MLUs has not been co-designed by rural women, irrespective of how many meetings they were allowed to attend. The response from women to the CCG closure recommendation has been one of shock and anger.

The CCG recognised the context: that *‘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...’*. The review outcome does not reflect what women have said.

Distance

On distance, and the fears around long journeys in labour, the CCG review report summarises views expressed by women:

Families and staff told us that in Shropshire, Telford and Wrekin, transport is a really important factor in their decisions and choices around birth and maternity care. People worried most about travelling to their place of birth when they were in labour and about birth before arrival.

Those based in urban settings do not mention any challenges around reaching their place of birth nor anxiety linked to that.... Women in rural areas have the added anxiety and pain that comes from traveling a distance to hospital in labour.

Because it is a rural county, giving birth in a safe place needed to take account of travelling times. One workshop suggested there needed to be a ‘maximum travel time to get to place of birth’ as a service quality criteria.

The issues are real. As a random example, we looked at Cwm, a small hamlet outside Clunton, in South West Shropshire. The travel time to Ludlow MLU is 28 minutes. To the MLU at Shrewsbury, the time increases to 57 minutes. To reach the Obstetric Unit at Telford, a woman will be travelling for an hour and 3 minutes.

The experience of those of us living in rural areas is that these are optimistic estimates. Journey times are strongly affected by poor weather, and by agricultural vehicles blocking minor roads. The A5 and

the A49 are 'hotspots' for road traffic accidents, and close as a result. Where overnight road works to the A roads take place, detours can and do result in huge increases to journey times. Last year, closure of the A5 between Oswestry and Shrewsbury saw diversions (via Welshpool) that more than doubled the journey duration. Also last year, regular closures of the A49 between Ludlow and Shrewsbury led to detours of up to 60 miles. The real experience of rural women is that travelling to Shrewsbury can be very difficult indeed.

Women have said, over and over again and in large numbers, that they need to be able to reach their intended place of birth quickly and easily. The CCG has not listened.

Continuity

Another theme identified by the CCG was continuity of care:

Women also highlighted continuity of care, and giving birth in a familiar environment:

...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.

Families living in both rural and urban communities told us they experience continuity and that they value it highly.

Yet 85% of women are currently denied continuity of care because of the use of the Obstetric Unit as the default option for giving birth. And the CCG proposals **end** continuity for women in rural areas, who will be **required** to travel to a distant location to give birth, cared for by staff they do not know. The proposal to centralise inpatient postnatal care at Telford is another (significant) strand in eroding the continuity of care that exists now.

Postnatal

care

And the third theme identified in the CCG review report – of **overwhelming** importance for rural women – is the strong support for the inpatient postnatal care on offer in rural MLUs:

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.

The rural cohort had generally experienced postnatal care in an MLU and their experiences were extremely positive, with MLU postnatal care described as exceptional; peaceful; relaxing; reassuring and a 'sanctuary'...

The experience at the Obstetric Unit is very different:

...postnatal care (in the consultant led unit) is a far less positive experience, with wards described as busy and chaotic; the experience 'too clinical' and women feeling isolated and 'pushed out' of the ward as soon as possible. Women do not blame postnatal ward staff for this. They feel it is system/resource rather than a relationship problem.

And yet postnatal care beds are to be reduced from 60 to 26 under CCG proposals, and those beds will be based only at the Obstetric Unit – far, far away from where most women in our rural communities live. This is a cost-driven change, and has nothing to do with the interests of women.

Inpatient postnatal care has gone out of fashion. It is about to be lost across most of Shropshire on the basis that it's out of date and no one does it any more. And yet women who experience the gentle,

personalised, empathic inpatient postnatal care at rural MLUs tell us that this experience is transformative. Do we listen to women – or do we just get rid of the care they value?

A note here from an Oswestry woman, who gave birth at Telford's Obstetric Unit a few weeks ago. Her comment reflects the pressure on postnatal beds and staff at Telford, as well as the unavailability of postnatal care at Oswestry MLU due to closure:

On Monday 12th at 1am my waters broke.....by 10pm on the 13th I was still in labour and exhausted and being taken to theatre for an emergency section. Lost a lot of blood during the operation and (was) eventually taken to a ward just after midnight , spent Wednesday uncomfortable and in pain on Thursday after another sleepless night I was discharged. Now had our local MLU been open I could have transferred for a bit of extra care where I could have gotten some rest and help as it so happens I'm now at home still struggling to move and have had to introduce some bottle feeds due to being so exhausted with Oswestry Maternity being a smaller unit I could of had the little bit of extra support to help me in these early days.....

This is not good care. The danger is that this is the future enshrined within current CCG proposals.

If Shropshire CCG is listening to women, it will fight with us to retain local maternity care, including local birthing facilities; it will improve continuity of care and carer, not take this away; and it will not so readily dismiss the lived experiences of women that MLU postnatal care is as brilliant as it could be. We want to see safe care and accessible maternity care; those things are not achieved by taking away the care that is already there.

[And what does local mean, anyway?](#)

The SaTH website records typical ambulance transfer times from its MLUs to the Obstetric Unit in Telford. From Ludlow, the time will be 83 minutes; from Bridgnorth, 68 minutes; and from Oswestry, 87 minutes. From Shrewsbury MLU, the estimate is 50 minutes. These estimates include ambulance response time as well as travel time. The continued insistence on the Obstetric Unit leaves women in rural areas facing lengthy and frightening journeys, often to care that meets their needs less well than a local MLU.

The CCG proposal is to encourage rural women with low risk pregnancies to give birth at the MLUs in Shrewsbury or at The Wrekin (Telford). We looked therefore at estimated car journey times⁸ to Shrewsbury from the existing MLUs: 46 minutes for Ludlow, 36 minutes for Bridgnorth, and 26 minutes for Oswestry. Those are likely to be *minimum* times, as these are the routes from main centres, not the scattered rural communities served by the MLUs in our market towns.

Ambulance response times are astonishingly poor in the rural areas of Shropshire, with waits of 45 to 60 minutes now commonplace even for life threatening calls. Many women travelling by ambulance would have to add a significant time to the estimates above.

A major concern around the closure of the rural MLUs is the loss of 24/7 face to face antenatal and postnatal advice at local level. A 24/7 phone line is not the same thing – because a Ludlow mother needing a face to face contact then needs – if she has access to a car – to undertake that 46 minutes each way journey to Shrewsbury. Taxis are not available at night, with local cab firms just not answering the phone. And if a taxi can be found, earlier in the evening, then the fare between Ludlow

⁸ AA Route Planner

and Shrewsbury Hospital is typically £40 to £50 for a **one way** journey. The trip for a quick check of a sick baby becomes time consuming and extremely expensive. The danger is that a woman who is worried overnight about her new born will take the risk and wait until morning. Mostly, that won't matter. Occasionally, it will.

Shropshire CCG typically regards Shrewsbury as 'local' for everyone living in the county. It isn't. Our existing MLUs offer local care – and we need to keep them.

National finance

NHS England introduced a sparsity adjustment in 2016/17, to meet the unavoidable costs of providing services in rural areas. Shropshire has the costs – but does not fit the tightly drawn criteria to attract the extra money. We hear from both Shropshire CCG and SaTH that the maternity tariff does not cover the costs of providing care in this area. We have every sympathy – but this is one for MPs to pass upwards, and is an area for NHS England to tackle. We do **not** accept that women and babies in Shropshire will pay the price for a funding formula that does not work.

The view from frontline staff

Nothing in this letter should in any way be seen as a criticism of midwives. Overwhelmingly, mothers in rural areas have had life enhancing support during pregnancy and when giving birth. We are well aware of the extreme unhappiness of midwives and WSAs with the current direction of travel.

The CCG review report summarises staff views:

Women's support assistants and midwives report that recent changes are compromising the care they are able to offer as there is not enough time during appointments and home visits. Staff are worried that 'something will be missed' as they don't have enough time with women. Increasingly, midwives do not feel in control of their working lives. They feel frustrated and angry. Staff feel disengaged from and let down by senior managers. Midwives report that not feeling in control is impacting on their work and home lives and on their emotional wellbeing, health and happiness. Staff feel they are letting their ladies down – especially in areas where there have been MLU closures.

Yes, absolutely right. The solution is that we stop letting down rural women **and** the health workers who care for them. Fewer midwives and fewer WSAs will not lead to more control and improved wellbeing of maternity staff.

What do we want?

In a nutshell: safe, high quality, accessible maternity care for all women in Shropshire, Telford and Wrekin – including women living in Shropshire's rural communities.

Concretely, immediately and urgently:

- We need SaTH to stop its relentless games playing designed to undermine and close rural MLUs. It is repugnant, creates risk, and is surely unacceptable.
- Shropshire CCG's proposals have been put into a 'Pre-Consultation Business Case', to be considered by the Clinical Senate. We have asked for a copy of that document; as yet, we do not know if the CCG is willing to make it public.

- We welcome the involvement of the Clinical Senate. We have asked Shropshire CCG to consider submitting to the Clinical Senate a paper from maternity campaigners on rural maternity services. The Clinical Senate will only consider wider views if they are submitted by the CCG. The request was made some weeks ago, and there is a local precedent for this. As yet, we do not know if the CCG will agree.

We also hope – but have no strong expectation – that the funding crisis in the NHS, and the particular difficulties facing rural areas and maternity care in rural areas, will start to be addressed.

There is a real fear now in rural communities in Shropshire. Women in rural Shropshire believe that our lives, and our babies' lives, are as important as the lives of women and babies in urban areas. We also believe that local NHS decision makers in practice disagree. They occasionally mention rurality – but there is limited willingness to meet the needs of rural communities. One of the reasons being put forward to justify closing rural MLUs is that they have been there, with the same basic model of care, for as long as 30 years. Surely this simply reflects a basic reality. Women in rural areas have always needed access to safe and accessible maternity care. Women *still* need that access.

Bobbie Brown, Save Bridgnorth Maternity Unit campaign

Gill George, Shropshire, Telford and Wrekin Defend Our NHS

Liz Grayston, Save Oswestry Maternity Unit campaign

Alison Hiles, Save Ludlow Maternity Unit campaign

22nd March 2018