REPORT ON THE PROPOSALS FOR MATERNITY SERVICES IN THE BUILDING BETTER HOSPITALS FOR THE FUTURE PUBLIC CONSULTATION

Context and summary of proposals for inpatient maternity care

NHS leaders have been wanting for some years to move acute hospital services, including maternity services, off the site of the Leicester General Hospital (LGH) and to transfer them to the sites of the Leicester Royal Infirmary (LRI) and Glenfield Hospitals (GH). NHS leaders have now been assured that, subject to public consultation, they will receive from government capital funding of £450m to implement this reorganisation of hospital services, resulting in some new build and some refurbishment on the sites of the Royal Infirmary and Glenfield Hospital, the closure of the Leicester General Hospital as an acute hospital and the sale of much of the hospital buildings and land at the Leicester General Hospital. Formal public consultation entitled '*Building Better Hospitals For the Future*' began on 28th September 2020 and will close on 21st December 2020.

At present University Hospitals of Leicester (UHL) offers an Obstetric Unit (OU) and an Alongside Midwife Led Unit (AMU) at both Leicester Royal Infirmary and Leicester General Hospital. Additionally there is a Free-standing Midwife Led Unit (FMU) at St. Mary's Birth Centre, Melton Mowbray. An alongside midwife led unit is situated next to a Consultant led obstetric unit where more interventionist care is available if required. A free-standing or standalone midwife led unit is situated with no obstetric unit alongside. The units at LRI deliver 5,400 births, LGH 4,500 births and St Mary's 145 births according to the public event led by UHL /Clinical Commissioning Groups on 15 October 2020[1]. The units were built to deliver around 8,500 births but are now required to deliver approximately 10,000 births per year. Each year, about 1.5% of the births delivered by UHL staff take place at home[2]. In 2016/17, more than 5,000 birth

[1] A figure of 170 births at St Mary's was given in a UHL press release on 12th November 2020
[2] *LLR Transformational Plan for Maternity Services,* Appendix P to the Pre-Consultation Business Case, Dated 2018. Figures are for 2015/16.

deliveries were commissioned from providers outside Leicester, Leicestershire and Rutland for LLR expectant mothers[3].

The proposal is to close down the obstetric unit and the alongside midwife led unit at the General Hospital and to move all or most inpatient maternity services to a new Maternity Hospital at LRI, capable of delivering 11,000 births per annum and offering the most up to date facilities. The new Maternity Hospital will have both an alongside midwifery unit and obstetric provision. The free-standing midwife led unit at St Mary's, which has two birthing rooms, 8 postnatal beds and is staffed 24 hours a day, will close. There is the possibility, depending on the outcome of consultation, of a 12 month trial of a free-standing midwife led unit on the site of the Leicester General. The Pre-Consultation Business Case[4] makes it clear that if a midwife led unit at the General Hospital is trialled but does not demonstrate that it can achieve 500 births per annum, it will close without further consultation.

The Pre-Consultation Business Case (PCBC) justifies its proposals on the grounds that:

- There has been a decision to move other acute services away from the site of the Leicester General Hospital and this must apply to maternity services as well. This helps free up many of the buildings and much of the land on the site of the Leicester General Hospital for sale.

- Maternity facilities need to be able to cater for rising demand, and for more complex demand, for their services in ways which keep services safe.

- Staff shortages, particularly in medicine, create difficulties in staffing safely the neonatal units at both the LGH and the LRI. Relocation of all inpatient maternity services to LRI means that just one neonatal unit is required.

[3] *LLR Transformational Plan for Maternity Services*, Appendix P to the Pre-Consultation Business Case, Dated 2018.
[4] *Reconfiguration of acute and maternity services at University Hospitals of Leicester NHS Trust Pre-Consultation Business Case*, September 2020, p526; referred to here as Pre-Consultation Business Case or PCBC.

- Staff shortages, particularly medical shortages, create difficulties in staffing safely obstetric services on both the LRI and LGH sites.
- Services must be modernised to improve the experiences of expectant mothers.
- There will still be midwife led birthing and obstetric birthing on offer, alongside each other on the site of the LRI.
- Relatively few expectant mothers choose to have their babies at St Mary's. The Trust believes this is partly because expectant mothers prefer midwife led care which is close to acute and emergency back-up and partly because St Mary's is harder to access than a city location. Because of under-utilisation, S Mary's is considered unviable.

Women's Concerns

A new grassroots campaign to save St Mary's Birth Centre, a petition, which has so far attracted several thousand signatures, and views expressed at an NHS public engagement event on the reorganisation of hospital services in 2018 all suggest there are concerns among the women and other residents in the Melton Mowbray, East Leicestershire and Rutland area that the very highly regarded midwife led unit at St Mary's is closing. This is not the first time it has faced closure. Discussion about the closure of St Mary's Birth Centre extends back to 2005 at least and women have reported temporary closures over the years. Women and midwives also reported at the Melton Mowbray November 2018 NHS engagement event that, contrary to the claims of the NHS, the option of using St Mary's was not widely understood amongst midwives working elsewhere in the Trust and was not adequately publicised to expectant mothers.

Policy context and choice

A national review of maternity services entitled *Better Births, Improving Outcomes of Maternity Services in England*[5] was published in 2016. It made a number of recommendations as to how services should be redeveloped to meet the changing needs of women and babies. *Better Births* emphasises the importance of women's choice over their care in the care model to be developed through the Maternity Transformation Plan[6]. Women should be offered a choice at all stages and in all aspects of their pregnancy. This includes: choice of provider for antenatal, intrapartum and postnatal care; choice of birth setting; choice of pain management during the birth; choice regarding the involvement of their birth partner; and choice as to how to feed their baby.

NICE's guideline on intrapartum care (care during labour) for healthy women and babies[7] sets out the evidence for the safety of different birth settings and recommends that women should be given the choice of where to give birth. The guideline lists 4 birth settings which should be offered to women who are at low risk of complications: home, free-standing midwifery unit, alongside midwifery unit and obstetric unit.

The follow-up progress report on *Better Births*, entitled *Better Births Four Years On*[8], reiterates the importance of choice of place of birth and asks Local Maternity Systems to improve access to birth in midwifery settings (at home or in midwifery units) for those who want it.

The PCBC states that, as women will be able to choose a midwife led unit at the LRI, an obstetric unit at the LRI or home birth, the proposals meet national requirements for patient choice.

However, the Building Better Hospitals For the Future proposals significantly reduce choice for expectant mothers. There are two options. One of these retains more choice for mothers than the other. The first option moves most maternity services into a new Maternity Hospital on the site of the Royal

[5] *Better Births, Improving Outcomes of Maternity Services in England, The National Maternity Review*, 2016
[6] NHS England, Maternity Transformation Programme
[7] National Institute for Health and Care Excellence (NICE) *Intrapartum care for healthy women and babies: Clinical guideline* [CG190] Published 2014 Updated: 2017
[8] NHS England and NHS Improvement (2020) *Better Births Four Years On: A review of progress* March

Infirmary but establishes a midwife led unit at the General Hospital. Under these arrangements, the reduction in choice is as follows:

Table 1: Option 1 - Reduction of choice in the event a free-standing midwife led unit is created and retained on the site of the General Hospital

Current choice	Choice after reconfiguration
Midwife led unit (free-standing) – St Mary's	Midwife led unit (free-standing) General Hospital
Midwife led unit (alongside) – Leicester Royal Infirmary	Midwife led unit (alongside) – Leicester Royal Infirmary
Midwife led unit (alongside) – Leicester General Hospital)	Obstetric unit – Leicester Royal Infirmary
Obstetric unit (Royal Infirmary)	Home birth
Obstetric unit (General Hospital)	
Home birth	

Thus, in the Building Better Hospitals consultation, the public are being consulted on this option of a free-standing midwifery led unit on the site of the Leicester General Hospital. However, should this midwife led unit be trialled, it may well fail to meet the 500 births per annum criterion as, according to the Pre-Consultation Business Case, it is just a 12 month trial[9]. Within a few months of the start of the trial, many women are likely to choose the only alternative site, the Leicester Royal Infirmary, as they will be fearful that the unit will have closed by the time they give birth. Moreover, it takes time for word-of-mouth information about women's experiences in the unit to begin to circulate and for a new unit to become an established part of the spectrum of women's considered options. We assume that if the trial goes ahead, the midwife led unit will be housed in the premises of the existing maternity unit at the General Hospital but it is not clear if the £450m government investment includes any

[9] Pre-Consultation Business Case p181

capital expenditure required for the trial, or for the unit should it be retained after the trial. It has reportedly been confirmed during the consultation period that a trialled free-standing midwife led unit at LGH will not include postnatal beds as St Mary's currently does, itself a significant reduction in provision[10].

It is our belief that if the trial takes place on only a 12 month basis, the trial will probably fail. This outcome will be more likely if it is not actively championed by someone in a position of power or influence[11]. It is also possible that local NHS leaders, following consultation, will decide not even to trial a midwife led unit. In both instances, the outcome will be no maternity services provided on the site of the General Hospital. In this event, the reduction in choice presented to expectant mothers in the Building Better Hospitals proposals is this:

Table 2: Option 2 - Reduction in choice in the event there is no free-standing midwife led unit at the General Hospital

Current choice	**Choice after reconfiguration**
Midwife led unit (free-standing) – St Mary's	Midwife led unit (alongside) – Leicester Royal Infirmary
Midwife led unit (alongside) – Leicester Royal Infirmary	Obstetric unit – Leicester Royal Infirmary
Midwife led unit (alongside) – Leicester General Hospital)	Home birth
Obstetric unit (Royal Infirmary)	
Obstetric unit (General Hospital)	
Home birth	

[10] The Pre-Consultation Business Case (p6) states that St Mary's is unusual as a midwife led unit in including beds.
[11] M Kirkham et al (2012) Why births centres fail, *AIMS Journal*, 24, 2

Thus, as only a very small proportion of births take place at home, the vast majority of women face delivery at LRI without choice of alternative in Leicester, Leicestershire and Rutland should St Mary's be closed and the free-standing midwife led unit at the General Hospital not be established or be trialled but then closed down.

Research[12] has also highlighted difficulties for women across England in getting admitted to AMUs, which are sometimes temporarily closed to plug staffing gaps in the adjacent obstetric units, and having to receive care in obstetric units instead where greater medical intervention is likely. The Pre-Consultation Business Case does not say whether this is a problem for mothers giving birth in Leicester. The Pre-consultation Business Case does not state how many beds there will be in (a) the obstetric unit and (b) the midwifery led unit in the new Maternity Hospital at the Royal Infirmary. Partly because of this, we are unable to assess whether mothers in labour will find their choice *further* reduced in the coming years by being unable to get access to the midwife led unit at the Royal Infirmary for the birth of their babies.

Risks of placing all births in one building

Concern also exists about concentrating all births (except for the very small proportion of home births) onto one site.

The proposed maternity hospital is expected to cater for around 11,000 births each year. This would be an enormous maternity unit, reputedly not only the largest in the UK but also the largest in Europe[13]. Recent research suggests that the centralisation of care in obstetric units limits the time available for labouring and for professional care to support a physiological labour and birth (i.e. a 'watch and wait' approach while the mother is in labour. There is a tendency to earlier recourse to interventions which speed up the process to keep 'institutional time' rather than individual mother-in-labour time[14]. Other research

[12] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ* Open 2020

[13] The Rotunda Hospital in Dublin is sometimes described as the busiest maternity hospital in Europe; 8,409 babies were born there in 2017. *Rotunda Annual Report*, 2017.

[14] F Darling et al (2021) Facilitators and barriers to the implementation of a physiological approach during labour and birth: A systematic review and thematic synthesis, *Midwifery*, 92, 10286, 1

also points to the greater likelihood of medicalisation of childbirth in alongside midwifery units when compared with free-standing midwifery units. One of the reasons for this may be the experience of de-skilling as well as reduced confidence to make decisions autonmously which some midwives report after working in obstetric environments[15]. This may be more likely to happen where midwives have limited opportunity to work in midwife led units or where midwives are regularly switched between alongside midwifery and obstetric units[16].

If the use of the new maternity hospital is compromised through a fire, an infection outbreak or some other event, it is difficult to see how units in neighbouring cities such as Coventry and Nottingham can accommodate around 30 additional babies a day. What is more, the risks to the safety of mother and baby, where diversion to a maternity unit in a different city many miles away is required, must not be overlooked. Events which compromise the use of a building are very rare but their impact can be significant. However, the risk of "putting all our eggs in one basket" should the Royal Infirmary become the only site for births in Leicester, Leicestershire and Rutland is not included in the Building Better Hospitals risk register.

Additionally, access to the Leicester Royal Infirmary is regularly delayed by the high volume of traffic since the LRI is situated on one of the main routes into the city centre. Traffic build-up, roadworks or traffic incidents all contribute to a gridlocked road system.

It is in this congested part of the city, with higher traffic-related pollution than either of the other two acute hospital sites, that Building Better Hospitals envisages all babies will be born and all neonates will be cared for.

The value of free-standing midwife led units and care closer to home

There is little reference in the Building Better Hospitals for the Future documentation to the research evidence underpinning free-standing midwifery

[15] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895
[16] Kirkham, M. (2020) Sop, Starve, Shut: the modern birth centre process, *Midwifery Matters* 164, 6-8

units such as St Mary's Birth Centre and to the strengths and importance of such units in an overall spectrum of provision.

Good outcomes and high quality experience of mothers in free-standing midwife led units

There are significant obstacles to midwife led units reaching their full potential, especially free-standing midwife led units (FMUs), despite national guidelines recommending midwife led units for women at low obstetric risk, and a substantial evidence base for their use. Fourteen free-standing midwifery units were closed in England between 2008 and 2015[17]. Recently published research suggests that managers, midwives and clinicians in provider settings harbour considerable ambivalence about the safety of midwife units[18]. Free-standing midwife led units were especially vulnerable to negative beliefs about their efficacy even though they pre-date alongside midwife led units by decades, often under the title of maternity homes or general practitioner units. Further, this research found that, despite arguments put forward by service managers in relation to lack of demand, the majority of women in the focus groups reported lack of awareness of these services and lack of information provision about their options[19]. This is echoed in the experiences of some mothers in relation to St Mary's. In addition to this, discussions about preferred place of birth are often framed through a language of risk (but only certain kinds of risk) and the opportunity to use free-standing midwifery units to realise their full potential is rarely seized[20].

[17] J Rayment et al (2019) Barriers to women's access to alongside midwifery units in England, *Midwifery*, 77, 78-85

[18] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895

[19] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, 0:e033895. See also J Rayment et al (2018) An analysis of media reporting on the closure of free-standing midwifery units in England, *Women and Birth*; and K Coxon et al (2017) What influences birth place preferences, choices and decision-making amongst healthy women with straightforward pregnancies in the UK? A qualitative evidence synthesis using a 'best fit' framework approach, *BMC Pregnancy and Childbirth*, 17:13

[20] M Kirkham (2020) Sop, starve, shut: the modern birth centre process, *Midwifery Matters*, 164, 6-8. Kirkham also identifies other practices which undermine free-standing midwifery units including restricting hours, paring back staffing or moving staff around, and cutting back or eliminating antenatal and postnatal care.

Despite the greater hostility to free-standing midwife led units, research[21] finds that, with low risk mothers and adjusting for confounders, there is no significant difference in adverse perinatal outcomes between planned alongside midwifery and free-standing midwifery births or between midwife led units and obstetric units.

> "Overall, there were no significant differences in the odds of [adverse perinatal] outcome for births planned in any of the non-obstetric unit settings compared with planned births in obstetric units.[22]"

Further, the researchers found that the chances of having an instrumental delivery (such as forceps or ventouse suction cap) were reduced in free-standing midwife led units and the chances of having a 'straightforward vaginal birth' were higher in free-standing midwife led units than in alongside midwife led units. The authors conclude:

> "The odds of receiving individual interventions (augmentation, epidural or spinal analgesia, general anaesthesia, ventouse or forceps delivery, intrapartum caesarean section, episiotomy, active management of the third stage) were lower in all three non-obstetric unit settings, with the greatest reductions seen for planned home and freestanding midwifery unit births []. The proportion of women with a "normal birth" (birth without induction of labour, epidural or spinal analgesia, general anaesthesia, forceps or ventouse delivery, caesarean section, or episiotomy) varied from 58% for planned obstetric unit births to 76% in alongside midwifery units, 83% in freestanding midwifery units, and 88% for planned home births; the adjusted odds of having a "normal birth" were significantly higher in all three non-obstetric unit settings []. For other maternal

[21] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343,* p.d7400; J Hollowell et al. (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk 'births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

[22] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343,* p.d7400

> outcomes (third or fourth degree perineal trauma, maternal blood transfusion, and maternal admission to higher level care), there was no consistent relation with planned place of birth, although these adverse outcomes were generally lowest for planned births in freestanding midwifery units.[23]"

> "Our analysis confirms that 'low risk' women who planned birth in a [free-standing midwife led unit] had lower rates of instrumental delivery and higher rates of straightforward vaginal birth compared with women who planned birth in an [alongside midwife led unit]; and that outcomes for babies did not appear to differ between births planned in free-standing midwife led units] and [alongside midwife led units]. In general, women who planned birth in a [free-standing midwife led unit] tended to experience lower intervention rates than women who planned birth in an [alongside midwife led unit].[24]"

Free-standing midwifery led units have the additional advantage of being a more local provision for some women, particularly where these are located in a different town from that where the larger obstetric units are located, and therefore meeting the wider health service principle of moving care closer to home. This is the case with St Mary's which, located in Melton Mowbray, is the only Leicester, Leicestershire and Rutland birth unit for women outside the city of Leicester. Moreover, Melton Mowbray is located in the east of Leicestershire County and it is the residents of East Leicestershire and neighbouring Rutland who are most affected, in terms of travel time, by the closure of the Leicester General Hospital and concentration of services on the other two hospital sites.

Further, the highly valued inpatient postnatal care, in particular breastfeeding support, provided at St Mary's is taken up by far wider group of mothers than those who choose to give birth there. As the Care Quality Commission inspection of UHL maternity care noted, St Mary's postnatal care has particular

[23] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343*, p.d7400

[24] J Hollowell et al. (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk 'births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

benefits for mothers with complex needs such as women with physical disabilities or mental health conditions[25]. Too little importance is placed on this.

A recent England-wide research project[26] on midwifery-led units recommended that both alongside midwifery units and free-standing midwifery units be embedded as standard care options for birthing women in addition to obstetric units, not only to address women's choice of place of birth but because they reduce the rate of caesarean section[27] and are cheaper. In addition, the research concluded that the provision of new free-standing midwifery units, a model unfamiliar to most women, must be implemented as a permanent service provision on the back of extensive promotion by providers.

Economic viability of free-standing midwife led units

Building Better Hospitals For the Future states that each midwife led unit has running costs of £1.405m (a figure which we are told is based on St Mary's Birth Centre the running costs which are less than half this each year[28]) and that with these running costs, a midwife led unit must deliver 500 births to be viable. The impression is given that St Mary's is too expensive for the number of births which take place there each year and that the annual costs of running a midwife led unit can be justified only with that number of deliveries. However, the Birthplace in England Programme found that free-standing midwifery units provided the most cost-effective birthplace for women at low risk of complications. Researchers[29] point out:

> "Trusts also need to value their [free-standing midwife led unit(s)] as central to the broader maternity service provision and an important choice

[25] CQC (2018) University Hospitals of Leicester NHS Trust: Inspection Report, Care Quality Commission
[26] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895
[27] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343*, p.d7400
[28] A Freedom of Information response states St Mary's cost £636,951 to run in 2019/20 https://www.whatdotheyknow.com/request/st_marys_birthing_centre_melton?nocache=incoming-1668357#incoming-1668357
[29] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895

> for low risk women. In particular, the common perception that [free-standing midwife led units] are a financial burden unless operating at maximum capacity needs to be challenged as the available evidence suggests that they are cheaper than supporting the same women to birth in an [obstetric unit], even when the [midwife unit] is operating at around 30% capacity. This is because health economists factored in the savings they generate in reduced intervention and maternal morbidity[30],[31]."

Free-standing midwife led unit facilities could also be used more extensively for other outpatient services and could arguably operate as part of a community hub as envisioned by the Implementing Better Births[32] policy document.

Care closer to home

Better Births points to the value of Community Hubs which provide coordinated care services[33] built around the needs of a specific local population, which may include prevention pathways, such as smoking cessation services, and other services working in partnership with local authorities. In some areas this has helped improve access to care. In Lincolnshire, for example, hubs have been opened in children's centres in towns like Skegness and Mablethorpe, from which women have previously had to travel to the nearest hospital for all maternity care. A small number of community hubs are trialling open on demand birthing rooms to increase availability of midwifery birth settings.

An alternative which local NHS leaders could consider is to expand the St Mary's Birth Centre model by establishing Community hubs to provide coordinated care services built around the needs of a specific local population.

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[30] Schroeder E, Petrou S, Patel N, et al. (2012) Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the birthplace in England national prospective cohort study. *BMJ*;344:e2292. These researchers found that analysing low risk women without complicating conditions at the start of care in labour revealed these cost differences between planned places of birth: total mean costs per birth were £1511 for an obstetric unit, £1426 for an alongside midwifery unit, £1405 for a free standing midwifery unit, Cost differences were driven largely by differences in overheads and staffing costs.

[31] Schroeder L, Patel N, Keeler M, et al. The economic costs of intrapartum care in tower Hamlets: a comparison between the cost of birth in a free-standing midwifery unit and hospital for women at low risk of obstetric complications. *Midwifery* 2017;45:28–35.

[32] NHS England (2017) *Implementing better births: a resource pack for local maternity systems*. Publications gateway Ref No. 06648. England: NHS.

[33] *Better Births Four Years On: A review of progress* March 2020

The advantage of a planned birth in a free-standing midwife led unit is lost should no such unit be retained. As mentioned above, less intervention among low risk women, when compared with planned birth in an alongside midwife led unit, provides a better experience for women and offers cost benefits to organisations[34].

As with other aspects of health care, little is said in Building Better Hospitals For the Future about services to be provided in the community settings making a full assessment of the adequacy of what is planned for maternity care difficult.

Options for pandemic preparedness

Covid-19 has shown the advantage of networked sites where Covid-19 and non Covid-19 cases can easily be separated. Apart from infection risks, there is a risk for healthcare resources. As indicated above, the evidence shows the planned delivery in FMUs require fewer caesarean sections, fewer instrumental births, far lower use of epidurals, significantly lower admission of mothers to higher level care or need for blood transfusion[35]. All these interventions require medical staff, particularly anaesthetists, who arguably hospitals may want to prioritise for ICU work in the context of a pandemic. Indeed some birth facilities at LRI and LGH had to be closed for a time during the spring 2020 Covid-19 pandemic but the remote site at St Mary's stayed open and offered its service to a wider geographical area. The number of babies born at St Mary's Birth centre increased from 76 in March-August 2019 to 92 in March-August 2020[36], an increase of over 20%, with double the number of babies being born at St Mary's in May 2020 in comparison with May 2019.

[34] J Hollowell et al. P (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk ' births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

[35] J Hollowell et al. P (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk ' births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

[36] Freedom of Information request DP/FOI/44286

Travel

At public meetings since at least 2015 concern[37] has also been expressed that getting to the Royal Infirmary from East Leicestershire and Rutland is difficult and time consuming. Some of the travel calculations contained in the proposals under-estimate the travel time required to come into Leicester City's centre from the furthest parts of LLR. Time from Rutland to the General Hospital is usually approximately 40 minutes by car irrespective of the time of day whereas it can take 1h15m or even 1h30m with parking to get to departments within the Royal Infirmary. One concern is that the number of inductions will increase and the number of births in transit will increase.

The concentration of maternity services on one site (LRI, with the tentative possibility of a FMU at The General Hospital) makes access more difficult for many women. Women must make decisions as to when to go to their chosen or allocated maternity unit once labour has started. Women are sometimes sent home from maternity units if midwives or doctors judge they have gone in too early. The advice from midwives in early labour is sometimes shaped by workload considerations, the availability of beds or rooms and the maternity unit's protocols[38]. Research[39] suggests the prospect of being sent home is a cause of significant anxiety to some women and that the transfer of women between place of birth and home and back again can give rise to distress and fatigue when women feel unsupported. This becomes more problematic in cases where women have to travel some distance since they may need to make the same lengthy journey three times in the same day[40]. The problem is exacerbated where the mother lives in a rural area and does not have access to a car.

There is also some concern that women sent home in early labour are at higher risk of giving birth outside a facility, without midwife attendance, and also at

[37] Healthwatch Rutland run event for Rutland women, Pre Consultation Business Case page 426
[38] S Beake et al (2018) Experiences of early labour management from perspectives of women, labour companions and health professionals: A systematic review of qualitative evidence, *Midwifery*, 57, 69-84
[39] J Rayment et al (2019) Barriers to women's access to alongside midwifery units in England, *Midwifery*, 77, 78-85; D Bick et al (2011) A case study evaluation of implementation of a care pathway to support normal birth in one English birth centre: anticipated benefits and unintended consequences. *BMC Pregnancy and Childbirth* 9-47, (Oct 5).
[40] S Beake et al (2018) Experiences of early labour management from perspectives of women, labour companions and health professionals: A systematic review of qualitative evidence, *Midwifery*, 57, 69-84

greater risk of trauma[41]. Births which take place unintentionally before the mother gets to the maternity unit are called 'births before arrival'. However, there does not appear to be a systematic collection of birth before arrival statistics at hospital trust level and what figures there are appear not be collated nationally[42]. It is difficult therefore to know how many of these births occur annually and whether these numbers are rising as maternity services become increasingly centralised. Many women interviewed for research studies have expressed real fear and anxiety about being at home without a midwife present and about getting back to the facility in time.[43] This problem is frequently overlooked by decision makers[44].

The staffing drivers of maternity reorganisation

Increasingly, the restructuring of health services is driven by workforce shortages. A key factor in the choice of a single building to accommodate all inpatient maternity services is a reported shortage in certain categories of staff, a shortage which is connected by local NHS leaders with a threat to the safety of mother and baby. This concerns not only the maternity services but also neonatal care. Staff shortages are exacerbated by the need to create separate staff rotas for different sites.

At present, a staffing rota for obstetric and midwife led units is required for the General Hospital and another staffing rota for each is required for the Royal Infirmary. Each hospital hosts a neonatal unit, with special care (level 1), high dependency (level 2) and the highest level of intensive care (level 3) at the

[41] H Shallow (2016) *Are you listening to me? An exploration of the interaction between mothers and midwives when labour begins,* PhD Thesis, University of the West of Scotland. The charity Birthrights has also expressed concern about women being turned away from their chosen place of birth when thought to be in early labour.
[42] In Scotland, a baby born before the mother reaches the hospital, for example in an ambulance, in the hospital car park or in a lift at a domestic address, is recorded as a hospital birth but with a maternity admissions code which signals baby born before arrival. It is not clear if this distinguishes between planned home births and unplanned births outside hospital. https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=S&ID=998&Title=SMR02%20-%20Summary%20of%20Rules/
[43] J Rayment et al (2019) Barriers to women's access to alongside midwifery units in England, *Midwifery*, 77, 78-85; D Bick et al (2011) A case study evaluation of implementation of a care pathway to support normal birth in one English birth centre: anticipated benefits and unintended consequences. *BMC Pregnancy and Childbirth* 9-47, (Oct 5).
[44] We have been in touch with several UK midwives who have expressed concern about the anxiety women feel at the prospect of being sent home in early labour, exacerbated by fear of travelling longer journeys in the context of service centralisation.

Royal Infirmary and special care only at the General Hospital. These two units must also be staffed. With the concentration of all maternity inpatient services into a new maternity building at the Royal Infirmary, neonatal care will also be centralised into one unit at the LRI.

Data underpinning this justification is scant in the documentation. The Pre-Consultation Business Case emphasises the shortage of medical staff. With regard to neonatal care, the two-site location of the service creates difficulties: several reviews have warned that insufficient consultant presence poses a risk to baby safety since a consultant can be present on only one neonatal unit at a time. In addition to this, we are told there are significant rota gaps arising from a shortage of junior doctors in neonatal care. There is a reference to a 'growing issue'[45] with neonatal nursing but no further detail is provided.

There is currently insufficient cot capacity in neonatal services and some babies are sent many miles away to other cities for care. The PCBC states the consolidation of neonatal services at LRI will entail increased capacity but no numbers are provided. By concentrating all neonatal services onto one site, no further consultant shortage is envisaged (there will be a consultant presence 24/7) and the impact of junior doctor shortages will be reduced. It is not clear what the extent of junior doctor shortage is in neonatal care. The Workforce Strategy and Plan (p39) states that, at any point in time, there are 50-100 vacancies in junior doctor posts across the Trust in all specialties.

Where maternity care is concerned, we are told there are local and national shortages of obstetricians and that women and children's services have the largest number of vacancies for junior doctors. Current recommendations state that a 60 hours per week consultant presence should be in place on maternity units delivering more than 6,000 births and that UHL struggles to maintain this standard. Neither the LRI nor LGH deliver this many babies annually but the numbers being born at the LRI are close to this figure.

Medical staffing gaps in the rota are expensive to fill and the PCBC states that these staffing problems are expected to worsen, endangering patient safety. Bringing all maternity services into one unit and all neonatal services into one

[45] Pre-Consultation Business Case p137

unit is seen as safeguarding the clinical sustainability and safety of the service in years to come.

Less is said in the Pre-Consultation Plan about midwives. The impression is gained from this that a shortage of midwives is a less significant problem and the Maternity Transformation Plan[46] states recruitment is positive. However, the PCBC also refers to a local and national shortage of midwives and the Workforce Plan appears to suggest 15 more midwives are required[47]. This may be to do with the number of births expected or partly because of the greater complexity of the work being undertaken as more women present with complex conditions and partly because additional midwives are required to meet continuity of carer requirements[48]. It isn't clear if the goal of achieving continuity of carer by delivering ante-natal and post-natal care through teams of 7-10 is in tension with a single site staffing strategy which seeks flexibility in staff deployment and easier management of rotas. In the Nursing and Midwifery workforce Plan[49], figures for vacancy rates and turnover rates do not distinguish between the nursing and midwifery workforces.

It is not clear how any shortages of midwives are alleviated in the event of all births in a single unit. Research[50] on the retention of midwives consistently demonstrates higher job satisfaction where greater autonomy is possible and higher rates of burnout where it is not. There is no discussion as to whether the closure of St Mary's will lead to the loss of midwives, as occurred with the centralisation of maternity services in Sheffield, or whether some midwives on the site of the General Hospital might not wish to move to an alongside midwife led unit on the site of the Royal Infirmary. Without more information, it is not possible to say whether the reconfiguration of maternity services might exacerbate rather than alleviate midwifery workforce problems

[46] *LLR Transformation in Maternity Services,* Appendix P to the Pre-Consultation Business Case
[47] *UHL Workforce Strategy and Plan 2018-2023* - Appendix I to the Pre-Consultation Business Case. The wording is rather cryptic: under a heading of "Demand", we have "15 Midwives agreed for investment in year with phased increases over subsequent years"
[48] *LLR Transformation in Maternity Services,* Appendix P to the Pre-Consultation Business Case
[49] *UHL People Strategy,* Appendix H to the Pre-Consultation Business Case.
[50] M Kirkham et al (2006) Why do midwives stay? Women's informed childbearing and health research group. *University of Sheffield, Sheffield*

It is not clear what the current and future employment, if any, of maternity support workers is (individuals who are under the supervision of midwives and can carry out some procedures - such as checking blood pressure or taking blood samples - but who have significantly less training than midwives and are not on a professional register). However, there may be an increase in the employment of such support workers as this would be consistent with the overall UHL workforce strategy in the coming years.

Better Births, the 2016 Cochrane Review and the *NHS Long Term Plan* (2019) all support continuity of carer. The LLR Transformation in Maternity Services document states most ante-natal and post-natal care will be provided by teams of 7-10 midwives working from a range of community venues so that expectant and newly delivered mothers receive all their midwifery care from a relatively small number of midwives. As mentioned above, it isn't clear if this is in tension with UHL's focus of single-site hospital based care for greater flexibility of staffing and easier management of rotas since these priorities may make continuity of carer less likely.

Conclusions and recommendations

The maternity reconfiguration proposals significantly reduce patient choice, an irony given the importance afforded to choice in maternity reviews and policy guidance.

The closure of the Leicester General Hospital results in much longer travel journeys for patients in East Leicestershire and Rutland when they need to access acute care in hospital. Removing St Mary's Birth Centre in Melton Mowbray exacerbates this problem.

Research shows that free-standing midwifery units offer high quality care for women at low risk of complications and are less interventionist than other institutional birth settings.

The literature suggests that free-standing midwifery units must be championed in order to succeed. This does not appear to have happened with St Mary's Birth Centre despite its reputation for highly valued care. It has not been enabled to realise its full potential as a free-standing midwifery unit able to

provide high quality birthing experience with reduced intervention for a larger number of low risk mothers.

We are concerned that the current plans provide no guarantee that a free-standing midwife led birth centre will be available, despite NICE guidelines that is should be offered and recommendations by researchers that both free-standing and alongside midwifery units be embedded into local systems of maternity care. Indeed, on the contrary, the fact that a trial only for such a unit is offered, and then that the trial is just a 12 month trial, points, we believe, to a lack of serious intent on the part of local NHS leaders.

We believe it is essential that a free-standing midwifery led birth centre is provided as part of the spectrum of care available to expectant mothers in Leicester, Leicestershire and Rutland.

We believe the research evidence on quality of care, consideration of pandemic preparedness, concerns about accessibility for residents on the eastern side of our geographical area and the significance of postnatal support, provide a strong case for the retention of St Mary's Birth Centre.

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