Northern Health and Social Care Trust

Acute Maternity Services Transformation

‘Frequently Asked Questions’

November 2022

What are the precise concerns that consultants are expressing and where/what is the evidence to back up these concerns?

The clinical team are concerned about the safety of a consultant-led maternity unit which has less than 900 births per year and has no neonatal facility. A maternity unit in the UK is described as small if it has less than 3,500 deliveries per year. The numbers of births in Causeway have seen year-on-year decrease and the birth rate is anticipated to fall below 900 by the end of 2022, despite diverting some appropriate activity from Antrim to Causeway Maternity. This equates to approximately 2.5 births per day and raises significant concerns in relation to the maintenance of skills for both medical and midwifery staff.

As Causeway does not have a neonatal unit, a risk stratified approach has been implemented by the Public Health Agency, which identifies women who are suitable to birth in Causeway Maternity. Any pregnancy or birth which has a higher risk of the baby requiring admission to a neonatal unit is transferred to Antrim for intrapartum care and birth. However, any baby has the potential to develop acute neonatal symptoms requiring treatment following birth or may require delivery in Causeway at any gestation, including preterm birth. Despite risk stratification, as a consultant-led unit Causeway still receives unscheduled attendances where women may not meet the risk stratified criteria for birth in Causeway and women with complexities still continue to give birth in Causeway and on occasion, babies need to be transferred out to a neonatal facility elsewhere.

In this circumstance, the midwives are supported by their paediatric colleagues to provide immediate neonatal resuscitation and stabilisation. Transfer of the baby to an acute hospital site with neonatal facilities is currently supported by the Northern Ireland Specialist Transport and Retrieval team (NISTAR). If these services are not available, Northern Ireland Ambulance Service (NIAS) will provide an ambulance and the transfer is undertaken by a paediatrician and a midwife, however this removes a midwife and the paediatrician from acute inpatient paediatrics and requires a second paediatrician to be available to cover. NISTAR have recently escalated concerns regarding transfer cover for paediatrics and neonates and highlight that they are currently experiencing significant gaps in their rota. This has a specific impact on the safety of services in Causeway in relation to the ability to provide safe and timely transfers of babies to a unit with neonatal facilities.

Due to risk stratification, in tandem with falling birth numbers, the resultant lack of exposure to complex cases and obstetric emergencies has resulted in intervention rates which are not consistent with a risk-stratified model of maternity care provision.

The clinical team do not want to wait for a catastrophic event to occur and have highlighted their concerns in a proactive way so we can plan for a safe and sustainable future model.

How many SAIs concerning maternity services at Causeway have there been over the last three years?

Over the last three years there has been one Serious Adverse Incident which relates to maternity services at Causeway. The team believe it is wrong to wait for harm to happen and have highlighted their concerns in a proactive way so we can plan for a safe and sustainable future model.

Have any babies come to harm or died as a result of the concerns that consultants have highlighted?

The team have worked exceptionally hard over a sustained period of time to mitigate the risks so that babies have not been harmed, however due to ever increasing staffing challenges, it is becoming increasingly difficult.

How many risk-averse interventions have occurred over the past three years as a result of deskilling and anxiety within the clinical team at CAU?

It is not possible to assign an exact figure regarding the causal link of deskilling of staff and intervention rates, however it is evident from the clinical outcomes reported on a monthly basis that the intervention levels are greater than would be expected for a risk stratified unit.

Will AAH be able to accommodate the increased demand?

The maternity unit in Antrim has 29 beds, and is physically constrained from further expansion in the current hospital configuration. Detailed modelling of daily occupancy rates across Antrim and Causeway identified 8 occasions between April and August 2022 when the combined occupancy of the two maternity units exceeded 29.

There are a number of measures which will mitigate the risk of over-capacity in a combined unit on the Antrim site:

- A number of capital works are underway to improve footprint and capacity in Antrim, specifically a new bereavement suite and two additional rooms for a day obstetric unit (DOU) for ambulatory care. Aside from the essential purpose of providing a bespoke bereavement suite for baby loss, this scheme also provides an additional birthing suite to increase capacity from 7 to 8 birthing rooms and can be incorporated into existing escalation plans for periods of increased activity. A further escalation space has been identified, bringing the potential total of birthing rooms at peak times to 9.

- The provision of two additional clinical rooms adjacent to maternity outpatients will enable the service to streamline scheduled and unscheduled ambulatory maternity care. This will provide a safer model and will also ease pressures in the current Fetal Maternal Assessment Unit (FMAU).

- Antrim maternity service has a shorter length of stay than the Causeway service, and there is a higher Caesarean section rate in Causeway than would be expected for a risk-stratified unit. It is therefore anticipated that efficiency gains will be made once the Causeway activity is diverted to Antrim.

- The provision of an elective caesarean list in Antrim main theatres will improve safety and quality, and will also ease pressures in delivery suite.

- There are further efficiency gains to be made through the introduction of ambulatory induction of labour pathways into the service.

What implications are there for other services in both CAU and AAH?

The implications for other services in CAU are dependent on what option is agreed in relation to a service model in Causeway. ED in particular will need to have pathways for women who might present to ED. There are also implications for the anaesthetic teams in Antrim if the service model changes. Work will continue with our teams in AAH and CAU to ensure that appropriate pathways/referrals in and out of the impacted services are as robust as possible.

What other options are being considered?

The consultation paper contains the options as we see them, along with an options appraisal. It is possible that the consultation process may throw up other options for consideration.

What is the timescale in relation to implementation?

All feedback arising from the consultation process which concludes on 3 March 2023 will be considered carefully and any final recommendation(s) in relation to changes will be presented to the Trust Board for approval. The Trust will then need to secure Strategic Planning and Performance (SPPG) and Public Health Agency (PHA) support and final approval will be required from the Department of Health/Minister.

Is this simply a cost-cutting exercise?

This is not a cost-cutting exercise in any way. This is predominantly a safety issue alongside staffing challenges in relation to recruitment and retention of clinical staff.

What do the proposed change(s) actually mean in practice?

This depends on the finally agreed option for a future service model.

How many staff will be impacted and at what grades?

This depends on the finally agreed option for a future service model.

Do all of the staff across impacted services agree that this is the right thing to be doing?

There is a strong sense of community and loyalty within Causeway teams, and staff are rightly very proud of the hospital they work in and the communities they serve. However impacted staff have been appraised of the current challenges in relation to the model of care and sustainability of the service and are broadly understanding of the position and the need for full public consultation on the options for change.

Are the Trade Unions backing the consultation and the options presented?

Trade Unions have been kept appraised of the need for/case for change, the options and the timetable in relation to public consultation etc.

What protection will be provided to staff whose base could change from CAU to AAH?

This will be dealt with in line with agreed Management of Change processes.
It is hoped that any change could be implemented with minimum disruption for staff. Suitable alternative roles will be offered to affected staff should this be required and employment contracts set out the protection arrangements in terms of pay and excess mileage.

What efforts have been made to recruit clinical staff for maternity services at CAU?

There is rolling recruitment for Band 5/6 midwives with 8-12 weekly interviewing. Recruitment to middle grade medical posts in Causeway has been on-going over a number of years with a number of permanent vacancies remaining unfilled on each occasion. Locum payment is at an enhanced rate in comparison to permanent posts and this is generally the more attractive option for that cohort of staff. The obstetric workforce is relatively small within the region and the consultant body are always aware of any available middle grades who are wanting permanent posts and respond accordingly to recruit.

Why is it proving so difficult to recruit staff to CAU?

Operationally providing comprehensive services that almost mirror each other on both sites is a significant workforce challenge, further complicated by difficulties with recruitment and retention of both the medical and midwifery workforce.

The *Strategy for Maternity Care in Northern Ireland 2012-2018* (DHSSPSNI 2012) stipulates that a consultant-led obstetric unit should be supported by resident ST3+ doctors or equivalent in obstetrics, paediatrics and anaesthetics. While the Antrim Maternity Unit conforms to these standards, Causeway maternity service presents challenges as the resident obstetrics middle grade rota is heavily dependent on locums and temporary staff and this is a potential risk to safe and quality care. Currently, the first on-call rota has 5 out of 8 posts covered by locums. The 2nd on-call middle grade rota is relying on locums for 3 out of 8 positions. This reliance on unpredictable locum medical staff is far from ideal. It is much better to build a well-trained, multi-professional team of clinicians who know each other and work and train together effectively to avoid harm to women and babies.

75% of obstetric trainees are female and data from the RCOG workforce census indicates that a large proportion of trainees and eventually consultants work less than full time. Competencies gained during training require that modern consultants work in teams rather than as isolated independent experts, which challenges the model of smaller rural maternity units where traditionally consultants with very broad skills and experience attempted to provide all services. This is no longer appropriate or feasible. Recruitment of new consultants must offer a modern team-based approach with on-call frequency and job plans that facilitate less than full time working and an acceptable work-life balance.

A retirement and another consultant leaving Causeway Obstetrics department has meant 40% of consultant on call activity is reliant on locum cover. A recent advertisement to recruit two new consultant obstetrician/ gynaecologist posts to the Causeway site, failed to attract any applicants. This is unprecedented and anecdotal feedback suggests that medical recruitment to Causeway is an unattractive option, both in terms of on-call frequency and skill enhancement. The impact of inability to recruit to the consultant tier is that the Causeway service is currently in an extremely vulnerable and precarious position and any unplanned absence may potentially result in an inability to provide 24/7 consultant cover.

Causeway only have trainees up to the level of ST2 and even then usually only for six months. This means we do not have the opportunity to train permanent staff to a middle grade level. It also prevents our permanent medical and midwifery team staff from learning from dynamic and motivated trainees at more senior levels.

Whilst midwifery vacancies are currently experienced by all Trusts, Causeway has historically struggled to recruit and retain midwives. Similar to the medical tier, feedback reflects lack of opportunity for experiential learning, particularly in younger, less experienced midwives. The sporadic lack of business and activity in the unit has also been voiced as unappealing to midwives.

Is this the beginning of the end for Causeway Hospital?

Not in the slightest. On the contrary, Causeway is of strategic importance to the Trust and we envisage a bright future and a very busy site delivering services which meet the health needs of the population moving forward.

What is your vision for CAU?

NISRA statistics suggest that the birth rate in the CC&G area will fall by 11% over the next 20 years and during the same period, the numbers of people over 75 years of age will increase by 65%. Those statistics provide clear indicators as to the services required with a greater focus on ambulatory pathways for frail older people, enhanced diagnostics and increased elective surgery. We are also in the early stages of considering what could be provided on the site in relation to the mental health needs of older people.

Will CAU still exist in three or five years time?

Yes, this is about ensuring Causeway's future is sustainable and the services provided on the site are fit for purpose and meet the health needs of the population

Will a full rural needs analysis be conducted?

This is a mandatory requirement. A Rural Needs Impact Assessment has been completed and published as part of the consultation documents.

If the consultation process and the feedback received reveals that there is no support for the preferred option(s), will the Trust take that on board and provide a solution that is acceptable to all?

The Trust will engage broadly during the consultation and will consider all feedback received. The final recommendation will take account of the views expressed and will seek to meet the objective of providing a safe, sustainable configuration of maternity services for the population of the Northern Trust. Final approval will be required from the Department of Health/Minister

How will women with no access to transport get to Antrim to deliver their baby – particularly in an emergency?

As is currently the case, woman who have no access to transport will contact NIAS in an emergency.

Have you done an analysis of the women in the Causeway area who are in the lower socio economic category who will have no access to transport and who rely on public transport – and what if these women have be in Antrim in the very early morning to have labour induced?

We will consider such situations on a case by case basis.

What about women who live in rural areas such as the Glens?

We have completed a Rural Needs Impact Assessment.

A Rural Needs Impact Assessment helps the Trust to understanding the impact the options are likely to have on people in rural areas.

Our initial assessment of impact in our rural communities has shown that there should be no differential impact in respect of local access to early pregnancy assessment units, antenatal and postnatal clinics and ambulatory services.

Under both of these proposals consultant led delivery will be based at Antrim Area Hospital site and therefore, for births that require this level of care, there is likely to be longer travel times and availability of transport issues, including the economic cost of transport arising, impacting upon economic needs. We will target our engagement and consultation with local rural communities and outlying areas to shape these options.

What engagement have you had with the ambulance service about this change and will they be able to transport women who are in labour?

Initial engagement with NIAS has not resulted in significant concerns around increased transfer activity. There were 183 transfers from Causeway both in utero and ex utero over the past 3 years, and evidence suggests that a Freestanding Midwifery Unit would not result in a significant change in this number. The Trust and NIAS have agreed that a robust public communications strategy and clear bypass protocols will be required.

NISTAR is currently experiencing issues with staffing and an ability to maintain consistent rotas. The service model in Causeway, where there is a consultant-led obstetric unit without an on-site neonatal unit, generates demand for NISTAR as neonates require transfer to Antrim for NNU admission. This is one of the key drivers for change, and a consolidated obstetrics service in Antrim would be expected to reduce NISTAR demand.

Are you concerned that babies may be born in the layby on the Frosses Road or other places on route to Antrim?

Individual discussions regarding when to come into hospital to birth their baby will be held with all women. For those who live furthest away, advice will be given in relation to the onset of labour and to present to hospital sooner rather than later. There may be some increase in Born Before Arrivals due to the increased travel time to Antrim, although there is no clear evidence that this correlates with increased perinatal morbidity or mortality.

How long have the Consultants been expressing concerns about the service in Causeway?

The sustainability issues in the Causeway obstetrics service have been evident for some time. The clinical team has worked hard to maintain the consultant-led service on the site but has concluded that this is no longer a viable service model.

Will women just have to go to Antrim for the delivery and where will they get pre and post-natal care?

Local access to high quality antenatal and postnatal services are critical for women living in our communities. These proposals will preserve and enhance the range of scheduled antenatal and postnatal care in Causeway Hospital. The only changes in terms of access is that around 600-900 women will make a single additional journey to the centre of their choice to give birth to their babies and if there is an urgent concern during the pregnancy then women will need to attend Antrim FMAU.

What will happen if a woman arrives in ED in Causeway in late stage labour, perhaps in the middle of the night?

This will depend on the final agreed model.

You have talked about preferred option(s) - what other options have you considered and where can we see the detail of the options appraisal?

The detail of the options appraisal is within the consultation document.

What if a woman would prefer to go to Altnagelvin or another hospital rather than Antrim?

Women can choose to book, receive antenatal care and give birth in Altnagelvin or any other hospital. However, if preferable, the NHSCT can still provide antenatal and postnatal care and woman can still give birth in another unit.

Could a woman opt for a home birth and is this service available in NHSCT?

The NHSCT provides a homebirth service and women who are assessed to be at low risk of complications during pregnancy and birth are suitable for this option of place of birth.

Can you demonstrate that the alternative service in Antrim will be safer than the current service in Causeway?

The safest model of maternity care is a consultant-led unit which provides care for women who have complexities in pregnancy with immediate access to a neonatal unit. Women who have been assessed as low risk for pregnancy and birth are safe to birth at home or in a Midwifery-led Unit. These are the models of maternity care on which the Trust is consulting.