Review of the North West London maternity and neonatal service transition of July 2015

March 2016
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Executive summary

To improve the quality of care for mothers and babies across North West London, maternity services in the region underwent significant change in July 2015, including the closure of Ealing Hospital’s maternity unit and development of community services. These clinically-led changes were essential to: respond to the increasing number of women with complex health needs during pregnancy; provide consistent high-quality maternity care by concentrating staff, expertise and resources in fewer centres and; increase the number of midwives and the hours of senior consultant cover.

This maternity review has found that the changes have been made safely and patients are now seeing improvements to their care.

All women booked to give birth at Ealing Hospital prior to the changes had their care transferred safely to nearby hospitals. Across NW London, we have improved the midwife to birth ratio to meet national standards, and all six maternity units have increased hours of senior consultant cover. Despite national shortages of staff, 100 new midwives have been recruited to NW London as a result of these changes. In Ealing there is now improved continuity of antenatal and postnatal care closer to people’s homes and we are also piloting a new perinatal mental health service for the area.

This report considers how the change has been managed and evaluates progress made on the expected the benefits. The report sets out key recommendations where further work is needed and where lessons of best practice should be shared with the wider NHS.

Maternity care in NW London will continue to be developed and monitored closely and a further review will be made in 2017.
Chapter summary

Chapter 1: Context

The maternity changes – or transition – were made as part of the clinically led Shaping a Healthier Future (SaHF) programme to improve healthcare for the two million people across NW London.

There were three primary reasons why maternity services needed to be changed:

- there are an increasing number of women with complex healthcare needs during pregnancy in NW London
- maternity units in NW London need to provide consistent high-quality, safe care, in line with the London Quality Standards. This could only be achieved by having fewer units to better concentrate staff, expertise and resources
- the need to increase the number of midwives so that one to one (1:1) midwife care in labour can be achieved for 100% of women and to assist maternity units in moving towards 168 hours of consultant presence on delivery wards each week.

There are 19 clinical aims outlined for the transition of which 14 clinical aims have already been met. Progress has been made with the remaining five and work continues to deliver them in full. This is explored further throughout this report.

The 2016 national maternity review

In February 2016 the national maternity review, overseen by Baroness Cumberledge published its report “Better Births, Improving outcomes of maternity services in England” which sets out the five year forward plan for maternity services across the country.

The changes in NW London are aligned with this national vision meaning NW London is already delivering the majority of the standards of care outlined in the review.
Chapter 2: Transfer of women

In total, 778 women who were booked to deliver their babies at Ealing Hospital after the planned closure date of its maternity unit needed to be re-booked to a new delivery unit. Of those, just 15 did not get their first alternative choice.

All the women were transferred safely with no clinical incidents or concerns raised and by the end of January 2016 all had given birth.

Chapter 3: Maternity model of care

3.1 Early pregnancy care
Nationally, the aim is for all pregnant women to be booked into their chosen birth unit by the 12th week of pregnancy. Improvements in NW London mean we are meeting this and are now aiming to have women booked in before their 11th week of pregnancy.

As part of the changes, a Maternity Booking Service (MBS) was set up to manage demand and capacity centrally. The primary purpose is to assist women who are not able to get their first choice of maternity unit. Since October, all women have received their first choice.

3.2 Antenatal care
Women in Ealing now have more consistent community midwifery as midwives from West Middlesex, Northwick Park, St Mary’s, Queen Charlotte’s and Hillingdon hospitals are now providing antenatal clinics in 18 locations across Ealing, primarily through children’s centres and health centres. This means women in Ealing are able to see midwives from the same team throughout antenatal, birth and postnatal care.
St Mary’s, Queen Charlotte’s, West Middlesex, Northwick Park, and Hillingdon Hospitals also run antenatal clinics out of Ealing Hospital. Women can also request some antenatal and postnatal care in their own homes.

Since the changes have been made, all Ealing women have been able to be seen in the clinic location of their choice as long as their clinical needs can be met in the clinic.

However, many of the clinics in the community in Ealing are not being well used, including a low uptake of scanning appointments which are still available at Ealing Hospital for some women. A maternity diabetes clinic remains at Ealing Hospital but also has seen low uptake.

A significant amount of extra capacity was built into the system to ensure women could get an appointment where they requested. However, it is unclear whether women are choosing to go elsewhere as a preference or whether they are not being made aware that local clinics are available.

3.3 Care in labour and at birth

Women who deliver on a midwife-led unit have a lower risk of unnecessary intervention. There is now a midwife-led unit alongside every obstetric unit in NW London, including two new midwife-led units developed as part of these changes, giving women more choice in where they give birth.

There has been a 10% increase in women giving birth in midwife-led units since the changes were made, with 15% of all deliveries in NW London now taking place in a midwife-led unit.
A key focus of the changes was to improve midwifery staffing across NW London to meet the London Quality Standards’ minimum staffing ratio of one midwife to thirty births (1:30). Prior to the changes, only Northwick Park was meeting that standard.

All 88 midwives working at Ealing Hospital were transferred to other maternity units within NW London, and over 100 more midwives were recruited to the area as a result of the changes.

This has meant that, as well as Northwick Park, Chelsea and Westminster, Queen Charlotte’s and St Mary’s hospitals have all now managed to achieve the 1:30 standard. West Middlesex has improved but the ratio at Hillingdon Hospital has remained unchanged.

In line with the London Quality Standards, NW London is working to make sure that women receive one-to-one care from a midwife while they are in active labour. All hospitals have improved with the exception of St Mary’s and Queen Charlotte’s where performance has decreased. Current figures show that 94% of women receive one-to-one care, which is the same as the average prior to the changes.

The London Quality Standard for consultant cover is for 168 hours of consultant presence on delivery wards every week (i.e. consultant presence 24 hours a day 7 days a week). Prior to the change, Ealing Hospital was achieving 60 hours of consultant cover – lower than all neighbouring hospitals. NW London set out to achieve 123 hours in 2015/16 and is on track to achieve that target with five out of six hospitals now providing more obstetric consultant-led care than they did before the changes.

To ensure the benefits of the changes are being realised, trusts are reporting against a set of quality metrics each month which are being monitored by the NW London Clinical Board.

3.4 Postnatal care
As part of the changes, trusts worked together to review their catchment boundaries for maternity care to help improve continuity of care. Before the changes, 42% of women had their postnatal care provided by a different hospital trust to their antenatal care. This has now reduced to 21%, meaning more women are seeing improvements in the continuity of their care as a result of the changes.

One major development in clinical care is the implementation of ‘transitional care units’. These units provide the additional support that some babies require, whilst allowing mother and baby to remain together on the postnatal ward.
There has also been an improvement in breastfeeding initiation rates in every unit except for Northwick Park and West Middlesex hospitals. Queen Charlotte’s and St Mary’s have introduced a community breastfeeding support service and Hillingdon has a new feeding coordinator for infants.

As part of the changes, it was agreed to develop mental health care relating to pregnancy and birth. Recruitment for staff is now complete and the perinatal mental health service is now being piloted.

Chapter 4: Demand on maternity services

Planning for the changes include 3000 expected deliveries moving from Ealing Hospital. This is 500 more deliveries than Ealing Hospital saw on average, building in capacity for potential population increases. As expected, the majority of women from around Ealing Hospital have chosen to book at West Middlesex or Hillingdon hospitals.

There has been no change in the overall volume of deliveries since the transition and forecasts show that no maternity unit will exceed the number of births they expected from Ealing. However, other factors – including a growth in births from Brent – means Northwick Park Hospital is projected to exceed its maximum annual capacity if no action is taken.

Chapter 5: Interdependent services

5.1 Neonatal services
The unit closed safely on 29 June 2015 with no babies in the unit at the time of closure that required transfer.

As a result of these changes, 15 neonatal cots were put in place at the other hospitals in NW London, which includes the cots reassigned from Ealing Hospital.

All twelve neonatal nurses working at Ealing Hospital were able to transfer to their first choice of hospital and are settling in well.

While the average numbers of transfers within NW London have not changed, there has been an increase in transfers to other networks due to lack of intensive care capacity for babies needing surgical care. However, Ealing Hospital did not previously this level of care, therefore this increase in demand is unrelated to the closure at Ealing.

5.2 Emergency gynaecology service at Ealing Hospital
Ealing Hospital continues to provide planned inpatient and outpatient gynaecology services on-site. It also now provides new emergency gynaecology services to support the emergency department at Ealing Hospital. These included an enhanced gynaecology emergency clinic at Ealing Hospital during the week, incorporating an
early pregnancy assessment unit, and an emergency gynaecology clinic at the weekend.

All the early pregnancy assessment units across NW London have seen average numbers of attendance increase, including at Ealing Hospital, following the transition.

Chapter 6: Women’s experience

A survey was undertaken with women whose care was moved from Ealing Hospital. 778 postal surveys (with freepost return envelope) were sent out and face-to-face surveys took place in two children’s centres in NW London. In total there were 103 responses (13%), which is higher than expected for this type of survey.

6.1 Information and materials

76% said they had received information about hospital choices and travel

63% received this in the post

55% received this from their midwife

72% felt they had enough information about where they could choose to give birth and 74% felt they had enough information about travel

10% said they would have liked more travel information on parking and travel by car
6.2 Travel to access care

Only 45% said their midwife asked about their travel plans when they had their care moved.

A quarter felt less able to get to appointments on time after they were moved. Some women did highlight an increase in travel time – especially where public transport was involved.

68% said the change did not make it harder for them to attend their antenatal appointments.

6.3 Overall experience of care

59% felt supported through the transition but 26% did not.

Once under the care of their new unit 79% were happy with the care they received.

6.4 Experience of women living in Southall

Thirty three women from Southall completed the experience survey which is a third of all respondents.

- under the care of their new units most women (75%) were happy with the care that they received
- 75% agreed they had received enough information about other hospitals where they could choose to give birth
- 78% indicated they received enough information about travel
- However a larger percentage of Southall women indicated that it had become harder for them to attend their antenatal/postnatal appointments on time, 36% compared to 19% of the overall survey respondents. This could be driven by the fact that only 28% of the Southall women indicated that they received antenatal or postnatal care locally from a children’s centre or health centre.
Chapter 7: Staff experience

7.1 Approach to staff transfers
The priorities for staff focussed on retaining skills and knowledge within NW London as well as increasing the overall number of midwives in the area. There were no redundancies, or resignations, as a result of transition and training bursaries were provided to staff transferring to another unit.

However a change in date of transition – and a period of uncertainty around that date – did have a negative impact on staff morale.

Whilst vacancy rates in midwifery continue to be a national issue, significant improvements have been made in NW London as a result of the transition. In total, an equivalent of 100 additional full time midwives were recruited.

7.2 Clinical leadership
Strong relationships were forged between clinical leaders as the heads of midwifery from all trusts came together on a regular basis to implement the changes. This combined expertise has been instrumental in driving up clinical quality. Community midwifery leads continue to meet weekly to review and refine care provision as appropriate.

7.3 Midwifery staff
Focus groups were undertaken in January 2016 with 29 midwives at four out of the five trusts to obtain feedback on the transition and learn for the future.

Most midwives spoken to from Ealing did not find the transition straight forward and raised issues around the uncertainty of the closure date and the speed of the transition. There was a divide between these midwives over the effectiveness of communications to them, with some receiving information from many sources and others saying they hadn’t received any personal communications. Equally there were varying issues around travel, with some finding their commute shorter whilst others experienced longer journeys. The majority of midwives had now settled into their new jobs well.

A number of midwives commented that they felt their workload had increased post-transition and raised issues associated with this. The majority of the midwives at the focus groups felt that the level of care they were individually providing had remained the same. As has been highlighted in other areas of this report, quality indicators have indicated that the cumulative effect of all the changes have meant that levels of care have improved.

7.4 Midwifery trainees
Midwifery trainees commented on the positive aspects of moving from Ealing Hospital and felt they were able to make informed choices about which units to transfer to.
7.5 Obstetrics and gynaecology postgraduate medical trainees
Six obstetrics and gynaecology postgraduate medical trainees based at Ealing were matched to an alternative hospital in line with their normal cycle of rotations and no trainees failed to meet their annual competencies as a direct result of the transition. A survey to all obstetrics and gynaecology trainees in NW London found a general feeling that workload had increased but there was a split view on whether this increase in workload has positively or negatively impacted their training.

7.6 General Practitioners (GPs)
A survey to GPs also went out across four boroughs with 21 practices responding.

All GPs felt that women usually need some form of support in making an informed choice and 57% felt the information they had received from their CCG (75% in Ealing) had been useful in helping to communicate the changes.

Best practice learning and recommendations can be found in chapter 8 of this report.
Chapter 1: Context

1.1 Background

Shaping a Healthier Future (SaHF) is a clinically led programme to improve care for the two million people across North West (NW) London. In February 2013, following on from extensive public consultation in summer 2012, the Joint Committee of Primary Care Trusts agreed the proposals set out under SaHF. This included the reconfiguration of maternity services across the area to improve the quality of maternity care. In October 2013, based on advice from the Independent Reconfiguration Panel (IRP), the Secretary of State endorsed the SaHF decision to transition inpatient maternity, neonatal, and interdependent gynaecology services from Ealing Hospital to six other hospitals in NW London. On 20th May 2015, Ealing CCG Governing Body agreed the timing of the transition of services. The transition of these services was implemented on 1st July 2015. This introduced new arrangements for community maternity across NW London, provided new facilities for community clinics in Ealing and inpatient obstetric units at hospitals across NW London and closed the inpatient maternity and neonatal unit at Ealing Hospital.

There were three primary reasons why maternity services needed to be changed:

1. there are an increasing number of women with complex healthcare needs during pregnancy in NW London,
2. maternity units in NW London need to provide consistent high-quality, safe care, in line with the London Quality Standards. This could only be achieved by having fewer units to better concentrate staff, expertise and resources,
3. the need to increase the number of midwives so that one to one (1:1) midwife care in labour can be achieved for 100% of women and to assist maternity units in moving towards 168 hours (24/7) of consultant presence on delivery wards each week.

In June 2015, the Ealing Maternity Transition Safety Committee recommended that an interim review was undertaken six months after the transition to:

- Conduct an initial assessment of the planned benefits and their realisation,
- highlight the good practice that has developed as a result of the transition, including evaluating the clinical benefits, estate developments, and further benefits,
- Identify any areas that require further development in order to realise additional benefits.
1.2 Benefits case

The model of care for maternity services in NW London set out a clear objective and expected outcomes that the transition of services should achieve.

The objective was to introduce a consistent model of care for maternity and newborn services in NW London to:

- Improve equity of access to the same levels of care.
- Provide care closer to home.
- Offer a choice in location of antenatal care, birth setting and postnatal care.
- Improve continuity of care for women throughout their antenatal and postnatal pathway.

The following table outlines the objectives for the development of maternity care services in NW London and provides an overview of progress towards achieving these in the first six months following transition. These are explored in more detail through this report. This snapshot clearly demonstrates the rapid progress that has been made in improving care to women in NW London.

<table>
<thead>
<tr>
<th>Objectives of the transition</th>
<th>compliance</th>
<th>progress</th>
<th>Report section</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve equity of access to maternity care</td>
<td></td>
<td>96% of women referred for antenatal care now have a booking appointment before their 12th week of pregnancy. 3% improvement post transition</td>
<td>3.1.1</td>
</tr>
<tr>
<td>Offer a choice in location of antenatal care, birth setting and postnatal care.</td>
<td></td>
<td>Across NW London choice has been increased for antenatal care, birth and postnatal care increasing the range of clinic settings and introducing midwife-led birth units</td>
<td>3.2.1 and 3.3.1</td>
</tr>
<tr>
<td>Improve continuity of care for women throughout their antenatal and postnatal pathway.</td>
<td></td>
<td>Through agreeing consistent pathways and more accurately matching trust catchment areas to women’s choice of delivery unit 79% of women now have the same provider for their whole maternity experience an increase of 21% since the transition (from 58%)</td>
<td>3.4.1</td>
</tr>
<tr>
<td>Choice of community setting with more care close to home (Children’s Centres, Health Centres, GP Surgeries, Community Hubs).</td>
<td></td>
<td>Care is provided in 18 children’s centres and health centres in Ealing, at Ealing hospital, and directly in women’s homes</td>
<td>3.2.1</td>
</tr>
<tr>
<td>Objectives of the transition</td>
<td>compliance</td>
<td>progress</td>
<td>Report section</td>
</tr>
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</tr>
<tr>
<td>A defined model of shared care between GPs, midwives and obstetricians as appropriate.</td>
<td></td>
<td>This element did not form specific part of the transition but has been highlighted as an areas that requires further work</td>
<td>3.2.2</td>
</tr>
<tr>
<td>Triage, treat and transfer protocols to avoid unnecessary admissions.</td>
<td></td>
<td>These have been agreed across the network.</td>
<td>3.4.4</td>
</tr>
<tr>
<td>Access to 24-hour maternity triage and emergency gynaecology services for women should problems occur.</td>
<td></td>
<td>Access to early pregnancy assessment unit services has increased with significant more capacity in Ealing. Usage of these facilities has increased significantly</td>
<td>5.2</td>
</tr>
<tr>
<td>1:1 midwifery care in active labour.</td>
<td></td>
<td>The percentage of women receiving 1:1 midwifery has remained constant at 94%, the aim is to achieve 100%</td>
<td>3.3.3</td>
</tr>
<tr>
<td>Improve midwife to birth ratios across NW London so all units achieve the minimum target of one midwife to thirty births (1:30).</td>
<td></td>
<td>The ratio has improved across from 1:31 to 1: as an average across NW London, however, two units remain outside this ratio. The unit with the worst ratio has improved from 1:35 to 1:32.</td>
<td>3.3.2</td>
</tr>
<tr>
<td>Increase consultant obstetric presence on the delivery ward (moving towards the target of 168 hours presence).</td>
<td></td>
<td>Since transition the average number of consultant hours on each obstetric ward has increased from 101 hours to 122 hours. Plans need to be agreed to achieve 168 hours</td>
<td>3.3.4</td>
</tr>
<tr>
<td>Choice of birth setting – home, midwifery led or obstetric led.</td>
<td></td>
<td>Women are able to choose to have their baby at home, in a midwife led unit or an obstetric unit. The number of midwife led units has increased and the number of births in these units has increased 10% since the transition.</td>
<td>3.3.1</td>
</tr>
<tr>
<td>Choice of setting - care either in home or close to home in community settings postnatal</td>
<td></td>
<td>Postnatal care is offered in women’s homes and in community settings</td>
<td>3.4.1</td>
</tr>
<tr>
<td>A model of Transitional Care for babies and an agreed Tariff</td>
<td></td>
<td>All units are now offering transitional care however, work needs to be undertaken to agree a common specification</td>
<td>3.4.3</td>
</tr>
<tr>
<td>Objectives of the transition</td>
<td>compliance</td>
<td>progress</td>
<td>Report section</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>Clear handover protocols and communication with identified healthcare professional for the transition to parenthood.</td>
<td></td>
<td>These are in place across the network</td>
<td>3.4.2</td>
</tr>
<tr>
<td>Enhanced children’s safeguarding through development of provider: borough protocols.</td>
<td></td>
<td>The safeguarding processes and paperwork have been standardised across NW London</td>
<td>3.4.2</td>
</tr>
<tr>
<td>Ensure sufficient cot capacity in NW London</td>
<td></td>
<td>Cots in the receiving hospitals were increased by 15. There has been no increase in transfers as a result of the maternity transition. However, there are an increasing number of babies in NW London requiring surgical cots and current capacity does not meet this demand. Chelsea and Westminster hospital are reviewing the capacity they can provide with a view to increasing provision</td>
<td>5.1.1</td>
</tr>
<tr>
<td>Clinical outcomes within national metrics</td>
<td></td>
<td>A comprehensive quality dashboard has been developed that enables oversight of key clinical outcome measures</td>
<td>3.3.5</td>
</tr>
<tr>
<td>Sufficient maternity delivery capacity in NW London</td>
<td></td>
<td>There is sufficient capacity across NW London and since October 2015 all women have been able to have their babies in their first choice of unit</td>
<td>4</td>
</tr>
</tbody>
</table>

**Good practice learning for future transitions 1:** It is important to agree a strong set of clinical quality aims with all stakeholders against which performance can be measured in addition to the more simple transitional process measures.

**1.3 The 2016 national maternity review**

In February 2016 the national maternity review, overseen by Baroness Cumberledge published its report "Better Births, Improving outcomes of maternity services in England". This sets out the five year forward plan for maternity services.
The report lays out a five-year vision for maternity:

“Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.”

The report pulls out a series of recommendations for the development of maternity services over the next five years to ensure the realisation of this vision.

It is reassuring, that although the transition in NW London predates the national review, the objectives set for the development of maternity services in NW London through the transition (as outlined in 1.2) align with the national vision and recommendations. As such NW London is already delivering the majority of the standards of care outlined in the review.

For example, there is a large focus on women receiving continuity of care in pregnancy. It suggests that women should be cared for by small teams of midwives who are able to provide this continuity of care. It also recommends that women should be provided with comprehensive information to support them to make their personalised choice in where to have their baby, either in a labour ward, birth centre or at home and that the service should wrap around them to support their choice.

The model of midwifery care implemented in NW London has small teams of community midwives providing continuity of care to women. The information booklet provides unbiased, comprehensive information to women to help inform their choice of maternity care and the estates investments undertaken through the transition ensure that women in all providers now have choice of giving birth in a labour ward, birth centre or at home.

Importantly the review recommends that professionals, providers and commissioners should come together on a larger geographical area through Clinical Networks, coterminous for both maternity and neonatal services, to share information, best practice and learning, to provide support and to advise about the commissioning of specialist services which support local maternity systems. The strong network of heads of midwifery, consultant obstetricians, commissioners and others is a positive outcome arising from the NW London transition; this is discussed later within this report.
The development of a quality dashboard to track, benchmark and improve quality is a further recommendation that has been developed by NW London through this transition.

There are, of course, recommendations from the national review that are not yet delivered within NW London such as a specific obstetrician being allocated to each small community team, and each women having electronic maternity records. It is therefore important that the NW London maternity network review the full recommendations of this report and develop an action plan to achieve all the recommendations over the next five years.

The report calls for volunteer localities to be identified as early adopters and it recommended that NW London volunteers for this.

**Recommendation 1:** NW London maternity network to assess current progress against the new national review recommendations and develop an action plan to deliver to them.

### 1.4 Governance

The review has been undertaken by an independent researcher and overseen by:

- Dr Mohini Parmar, Chair of Ealing CCG
- Dr Mark Spencer, Medical Director of Shaping a Healthier Future and Medical Director of NHS England London Region
- Pippa Nightingale, Director of Midwifery/Clinical Director of Women’s services at Chelsea and Westminster and West Middlesex Hospitals
- Carmel Cahill, Lay Member, Ealing CCG Governing Body
- Juliet Brown, Programme Director, Shaping a Healthier Future

The report has been independently reviewed by Donna Ockenden, Expert Midwife and Independent Healthcare Advisor.
Chapter 2: Transfer of women

The evidence provided to this review demonstrates that the transfer of inpatient maternity services from Ealing Hospital was a streamlined process, which was well planned and clinically led. Prior to the transition, all of the 969 women who were booked to give birth at Ealing Hospital were telephoned by a midwife about the planned changes. If a midwife was unable to contact a woman by telephone, they were visited at home. Following agreed protocols, 778 of the women who were contacted had a new delivery unit agreed and their care was transferred to the respective trust. This transfer process was undertaken as quickly as possible to reduce the uncertainty for women. The time from contacting the first women to all women having appointments with their new trust was eight weeks. Fifteen women were not able to be offered their first alternative choice of unit and their care was rearranged by the Maternity Booking Service, with reports that they were satisfied with the unit to which they were transferred. Clinical notes were transferred to the receiving units and a clinical review by a midwife, lead consultant and/or safeguarding lead as appropriate was undertaken for each woman to ensure that the right clinical and social pathways were implemented.

Of the remaining 191 women, 190 were contacted, but their care did not require to be transferred as either they delivered at Ealing Hospital in June, had moved out of the area or were no longer pregnant. Only one woman could not be contacted despite following a number of detailed procedures, including contacting her GP and attempting to visit her at home. The team have since been informed that she has moved out of area and registered with a GP out of London.

The maternity unit closed safely on 1st July 2015 and the clinical and operational teams who led and managed the transfer should be praised for the safe implementation of the transfer, which was on time, as planned, with no clinical incidents or concerns raised by local population or GPs. As of end January 2016, every woman who had their care transferred from Ealing Hospital has given birth.

**Good practice learning for future transitions 2:** Direct verbal contact with women, rather than relying on written communication, resulted in a smooth transfer and no unexpected births at Ealing following the transition.

**Good practice learning for future transitions 3:** The transfer process was clinically led and all women were clinically assessed prior to transfer ensuring appropriate care was put in place.

**Good practice learning for future transitions 4:** Vulnerable women were a clinical priority and received high priority in the acceptance criteria. This has been continued through the Maternity Booking Service so that vulnerable women are always able to access their first unit of choice.
Chapter 3: Maternity model of care

3.1 Early pregnancy care

The benefits case set out the following objectives for early pregnancy promoting improved access to care:

- To improve equity of access to maternity care including early access to maternity services by eleven weeks and six days of pregnancy.

3.1.1 Early access to booking appointments

Women are supported in making their choice for maternity care from the six maternity providers in NW London by GPs, other care providers and the Maternity Booking Service. There are, on average, 3,000 pregnancy booking appointments in NW London each month. During a booking appointment, a full medical and social needs assessment is conducted by a healthcare professional, who will also provide advice and support on lifestyle, breastfeeding, diagnostics and other pregnancy related matters. Specialised services such as translation, interpreting and advocacy services can also be offered at this time, if required.

Booking before the twelfth completed week of pregnancy is a national target, and the minimum standard is 90%. Post transition 96% of women are seen within this timeframe, compared to 93% before the transition. This 3% increase in compliance means 90 additional women per month are accessing maternity care on time.

This progress has been driven by a significant improvement in arranging timely booking appointments at St Mary’s Hospital, where 98% was achieved in November 2015, from a baseline of 88%. This is as a result of the improvement in the community midwifery model and increased provision of community clinics.

NW London is exceeding the national standard and the improved performance is evidence that the clinical standard of improving early access to maternity services has been achieved. This will continued to be monitored monthly to ensure compliance continues to improve and the trusts are now reviewing options to ensure women are seen by the 10th week and 6th day of pregnancy.
Table 1: Percentage of women referred before the 11th completed week of pregnancy that have a booking appointment before the 12th completed week of pregnancy

<table>
<thead>
<tr>
<th>Maternity Unit</th>
<th>Pre-transition Average</th>
<th>Post-transition</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>96%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte’s)</td>
<td>94%</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>Imperial (St Mary’s)</td>
<td>88%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>94%</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>North West London Average</td>
<td>93%</td>
<td>96%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Source: Maternity Quality Dashboard

3.1.2 The Maternity Booking Service

The Maternity Booking Service (MBS) was commissioned in November 2014. It aims to ensure women are offered a choice of maternity provider in NW London while managing demand and capacity centrally to support women's choices, improve their experience and prevent delays in booking appointments for antenatal care in line with the national maternity booking standard. Its primary purpose is to assist women who are not able to book into their first choice of maternity unit choose an alternative unit within NW London. It is coordinated using a bespoke Excel database, developed and managed by the MBS team. All referrals to MBS are clinically screened and vulnerable cases, such as women with safeguarding issues, are placed in their first preferred choice of unit.

The planning assumptions were made on a worst case scenario of 5% of women not receiving their first choice. However, to date only 1% of women have not received their first choice.

The 1% of women who did not receive their first choice (108 women, 58 who live in NW London) occurred in the first three months following transition and were unable to book into Hillingdon Hospital (THH). The project team were quick to respond to this and supported Hillingdon Hospital to refine their acceptance and booking processes. Since October all women have been accepted into their first choice trust and there have been no referrals to MBS, as demonstrated in Figure 1 below. This shows that the modelling of demand and capacity in preparation for the transition was sound and the changes are now embedding in the system. It should be recognised that there will be times when women will not receive their first choice of maternity unit. For this reason, the MBS will continue to operate to assist those women choose an alternative unit within NW London.

All women who were not placed in their first choice in the first three months were clinically screened. If safeguarding or vulnerable needs were present, they were accepted at Hillingdon Hospital. All other women were placed in their second choice trust within 72 hours.
Following redirection from Hillingdon Hospital, the most popular second choice maternity units for women from NW London are Queen Charlotte’s and Chelsea Hospital (Queen Charlotte’s Hospital) and West Middlesex University Hospital (West Middlesex Hospital). It is worth noting that the MBS has not had any problems communicating with women who have been referred to them and used appropriate translation services in four cases.

Not all women from NW London choose to have their baby at birth units in NW London. Should their chosen hospital, outside NW London, be fully booked they will be referred to the MBS to arrange an alternative NW London hospital. GPs have asked that further work is undertaken with neighbouring hospitals to establish this referral route more robustly.

There was no central booking system prior to transition, so it is not possible to provide comparative pre-transition data. Anecdotally, we know that a number of women did not receive their first choice of unit. In the absence of a Maternity Booking Service, women then either had to follow up themselves or a GP surgery would do it for them. The development of the MBS can therefore clearly be seen to have reduced waiting times and reduced uncertainty for many women.

**Good practice learning for future transitions 5:** A central booking system improves system resilience, minimises disruption for women who are unable to book into their first choice unit and improves access to care for women.
Recommendation 2: SaHF and the NW London clinic network should share the MBS model with the wider London network to consider if this approach should be taken across London. This would also assist women from NW London who choose to book outside of the sector.

3.2 Antenatal care

The benefits case for antenatal care promotes choice in care delivery through:

- choice of community setting with more care close to home (children’s centres, health centres, GP surgeries, community hubs)
- a defined model of shared care between GPs, midwives and obstetricians as appropriate,
- triage, treat, and transfer protocols to avoid unnecessary admissions.

3.2.1 Choice of care setting

The clinical aim when planning the transition was that the children’s centres in use in Ealing would continue and Ealing Hospital would be used as an additional community maternity clinic setting. It was also agreed that a consistent community midwifery model of care would exist across the sector.

This has been achieved and women in Ealing now have choice about where they would like to receive their maternity care. There are eighteen different locations across the borough (children’s centres and health centres). In addition West Middlesex Hospital, Northwick Park, St Mary’s, Queen Charlotte’s and Hillingdon Hospitals provide services from Ealing Hospital or women can attend clinics at the hospital where they have chosen to give birth. Midwives also provide postnatal and some antenatal care to women in their own homes.

All six maternity providers extended their community areas to encompass the Ealing community area, to ensure that high quality midwifery care could be provided in Ealing, so as to not to inconvenience the local women. New community clinics were also planned and delivered in children’s centres by Imperial College Healthcare Trust in areas of Brent and Chelsea and Westminster in Chiswick.

The majority of women are therefore now able to receive local maternity care, to agreed protocols, by midwifery teams from their chosen hospital, who provide their antenatal and postnatal care in a community setting where clinically appropriate.

The new midwifery clinics in children’s centres and health centres commenced 13 June 2015 and the Community Maternity Clinics at Ealing Hospital opened 6 July 2015. Northwick Park Hospital and Hillingdon Hospital also offer consultant-led antenatal clinics, specialist diabetic services and ultrasound scanning from the Ealing Hospital site.

Full details of the public information poster on the location for community care provision in Ealing Borough can be found in Appendix 1.
The clinical team made the decision to continue to provide community care in children’s centres, which are aligned with the wider multidisciplinary teams such as health visitors and social workers and all agree this is a good model. In the vast majority of areas this model is working well, however, the transition has highlighted some issues relating to the different commissioning arrangements for children centres (they are commissioned by local authorities). Children’s centres are funded in relation to local women attending the centre and the geographic boundaries do not map exactly to the maternity services. This has only caused difficulty in some areas of Chiswick where the funding arrangements have meant that some women have not been able to access their maternity care in a children’s centre as they do not live within the appropriate catchment area. To manage this, midwives have been visiting these women at home to prevent them having to travel into the hospital. It is also acknowledged that children’s centre funding in general is under review and this may have implications in the future.

The clinical project group continue to support the view that providing care in children centres is the best clinical alignment for women and health professionals. Providers need to work in partnership with commissioners and Local Authorities to understand the planned provision and role of children centres in the future and align service availability for women.

3.2.2 Shared care arrangements for antenatal care
As in the rest of the country, there are differing models within NW London with regard to antenatal care and the involvement of GPs and hospital maternity teams. This is commonly referred to as shared care. These arrangements were discussed in the planning phase of this transition and a decision was made not to progress changes to these arrangements at the same time as transition. As such the differing commissioning arrangements for shared antenatal care between GPs and the maternity providers continue and have not been resolved through the transition. The change in commissioning arrangements for Ealing patients has further highlighted the need to resolve this and it has been agreed that this will be progressed through 2016/17 contract negotiations.
**Recommendation 3:** Providers need to work in partnership with commissioners and local authorities to understand the planned provision and role of children centres in the future. Negotiations should be held with Chiswick children’s centres to agree access for local women.

**Recommendation 4:** Commissioners and providers need to work together to agree commissioning arrangements for shared antenatal care. In future transitions, contracting issues that affect transition should be managed within the transition framework.

### 3.2.3 Demand for outpatient maternity services

Providing sufficient outpatient capacity to support women’s choice and ensure future resilience were key planning concepts of the transition. Significant additional capacity was therefore built into the outpatient clinic capacity in Ealing Hospital, the children’s centres and health centres.

Since transition, all women have been able to be seen in the clinic location of their choice as long as their clinical needs can be met in the clinic.

At Ealing Hospital, 43 maternity clinics were initially planned. However due to the flexibility planned into the system, only 40% of the planned 43 clinics are running as there is not sufficient demand for the clinics. Furthermore, several of the clinics are underutilised, with many women choosing to have their care delivered at children's centres, health centres or the location of their maternity unit instead.

<table>
<thead>
<tr>
<th>Hospital Trust</th>
<th>Services Offered</th>
<th>Number of clinics planned</th>
<th>Number of clinics not started</th>
<th>Number of clinics in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>Not applicable</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>Antenatal care only</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Imperial</td>
<td>Bookings and antenatal care</td>
<td>18</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>London North West</td>
<td>Bookings and antenatal care</td>
<td>9</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>Antenatal care only</td>
<td>12</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Bookings and antenatal care</td>
<td>43</td>
<td>26</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: Community Midwifery Leads

The clinics run by Hillingdon Hospital and Imperial Healthcare Trust are well attended with more than 75% of appointments booked. In the two clinics run by West Middlesex Hospital however, one has less than 25% of appointments utilised and the other has 75% utilised. London North West Healthcare Trust is also running clinics which are under capacity, with two out of their five clinics only having 25-50% of appointments taken up. They are working to address this, including improved marketing of the site. Hillingdon Hospital’s scanning clinic is running as planned at Ealing Hospital, however only 51 - 75% of available appointments are booked. London North West Healthcare Trust were planning to run eight scanning clinics, but only three have been required to meet demand.
The trusts running clinics from the Ealing Hospital site report that the clinics are running well and they have overcome some early challenges regarding IT integration.

In the planning phases of the transition there was a strong view from the public that a diabetic service remained at Ealing. Both Hillingdon Hospital and London North West Healthcare Trust provide maternity diabetic clinics at Ealing Hospital. In similarity to the general maternity clinics there was significant over capacity planned and the services are not fully utilised. Further work is being undertaken by Hillingdon Hospital and London North West Healthcare Trust to review their diabetic pathways.

Trusts are also providing community clinics from the children’s centres and health centres in Ealing as planned (the only exception being that Imperial Healthcare Trust moved services from Mattock Lane Health Centre to Masbro Children’s Centre, as Mattock Lane were not able to provide a room for the clinic.) As seen at Ealing Hospital, demand from women for these community clinics is lower than planned, resulting in only 60% of the 65 clinics taking place. Another reason for lower utilisation at these clinics is that they also offer postnatal care, which is also offered directly in women’s homes, a preferable arrangement for many women.

Women who had their care transferred from Ealing Hospital during the transition provided feedback on the information they received about the range of options available to them, including access to maternity appointments. Further details are provided in Section 6: Women’s Experience.

**Recommendation 5:** Review the utilisation of clinics as Ealing Hospital and refine the clinic capacity and demand.

**Recommendation 6:** Providers should work with women in the area to highlight that they can access high quality antenatal care by the same team who will deliver their baby, without the need to travel to the centre where they have chosen to give birth.

**Recommendation 7:** Within the next six months the maternity diabetic pathway needs to be reviewed across the sector to ensure provision of specialist services to meet clinical need.
3.3 Care in labour and at birth

The benefits case set out the following objectives for labour and birth, promoting choice and appropriate skilled staffing levels:

- choice of birth setting – home, midwifery-led or obstetric-led.
- 1:1 midwifery care in active labour.
- increase in midwife to birth ratios across NW London so all units achieve the minimum target of one midwife to thirty births (1:30).
- increase consultant obstetric presence on the delivery ward (end point target for 168hrs presence, transition target average 123 hours per week).

3.3.1 Midwife-led units

Since the start of the planning for this transition there are now two additional midwife-led units in the sector and there is now a midwife-led unit alongside every obstetric-led unit in NW London, giving women more choice in delivery setting. There are now 31 midwife-led unit rooms in NW London. The following table shows the number of births in the midwife-led units each month for the NW London maternity units. This shows a 10% increase from 349 births per month in a midwife-led unit pre-transition to 371 per month post transition. The 31 midwife-led unit delivery rooms in NW London account for 32% of the 97 delivery rooms available, with 15% of all deliveries happening in a midwife-led unit. Although the birth occupancy may appear low at 32%, the length of stay for a woman in a midwife-led unit includes her inpatient postnatal stay therefore the overall occupancy is considerably higher. Further work should be undertaken to increase the percentage of women who deliver on a midwife-led unit as women who deliver in these units have a lower risk of unnecessary interventions and increased satisfaction.

Table 3: Number of monthly midwife-led unit deliveries by maternity unit

<table>
<thead>
<tr>
<th>Maternity Unit</th>
<th>Pre-transition</th>
<th>Post-transition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>57</td>
<td>53</td>
<td>59</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>5</td>
<td>43</td>
<td>*7</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte's)</td>
<td>66</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>Imperial (St Mary's)</td>
<td>60</td>
<td>57</td>
<td>49</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>49</td>
<td>71</td>
<td>42</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>76</td>
<td>98</td>
<td>82</td>
</tr>
<tr>
<td>Ealing Hospital</td>
<td>37</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NWL Monthly Total</td>
<td>349</td>
<td>392</td>
<td>319</td>
</tr>
</tbody>
</table>

*Data quality issue due to coding problem. Not included in post-transition average calculation.

Source: Maternity Quality Dashboard

Not surprisingly, the biggest increase in midwife-led unit deliveries has been at Hillingdon Hospital where this service was newly introduced at the time of transition. However, the number of midwife-led unit deliveries at St Mary's Hospital has dropped by an average of three per month post-transition. This is despite an overall increase in the number of deliveries at this unit. This may be due to the recent
refurbishment of the midwife-led unit at Queen Charlotte’s Hospital, so women booked with Imperial may be choosing to go to that unit instead.

**Recommendation 8:** In line with national and London-wide guidance, labour and birth in alongside midwifery-led units should be actively promoted for low risk mothers as they are associated with a lower risk of unnecessary interventions and increased satisfaction.

### 3.3.2 Midwife to birth ratio

The London Quality Standards set out a midwifery staffing ratio of a minimum of one midwife to thirty births (1:30) across all birth settings. Prior to the transition, the only receiving hospital achieving this standard was Northwick Park Hospital with a ratio of 1:24, which was an elevated ratio reflecting improvement work that was underway in 2015 following recommendations by the Care Quality Committee Care Quality Commission.

A focus of the transition was therefore to improve midwifery staffing at all receiving trusts, with the aim of improving the midwife to birth ratio at each site. There were 88 midwives working at Ealing Hospital at the time of the transition who were transferred to the other maternity units in the sector, resulting in an initial reduction in the vacancy rates at the receiving trusts. Furthermore, there was a concerted drive to recruit additional midwives to NW London in preparation for the transition, which dramatically increased the number of midwives working in the sector from 840 whole time equivalents (WTEs) in February 2015 to 939 WTEs in December 2015.

The following table compares the midwife to birth ratio, pre and post transition, for each maternity unit.

<table>
<thead>
<tr>
<th>Maternity Unit</th>
<th>Pre-transition</th>
<th>Post-transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>1:33</td>
<td>1:30</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>1:31</td>
<td>1:31</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte’s)</td>
<td>1:33</td>
<td>1:30</td>
</tr>
<tr>
<td>Imperial (St Mary’s)</td>
<td>1:33</td>
<td>1:30</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>1:24</td>
<td>1:27</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>1:35</td>
<td>1:32</td>
</tr>
<tr>
<td><strong>North West London Average</strong></td>
<td><strong>1:31</strong></td>
<td><strong>1:30</strong></td>
</tr>
</tbody>
</table>

Source: Maternity Quality Dashboard

Following the transition, Chelsea and Westminster Hospital, Queen Charlotte’s Hospital and St Mary’s Hospital have all improved midwifery cover to achieve the 1:30 standard. West Middlesex Hospital has improved since the transition to a ratio of 1:32, but further work is required at the unit to achieve the standard. Hillingdon Hospital’s ratio has not yet changed, but it is forecast to improve following recruitment of a number of additional midwives in December and January. Northwick Park Hospital has completed the improvement work requiring the unit to have an
elevated ratio, so this has been reduced to 1:27, which is still exceeds the London Quality Standards.

**Recommendation 9:** West Middlesex Hospital and Hillingdon Hospital should continue to actively recruit midwives to achieve the 1:30 target set out in the London Quality Standards and agree a plan to achieve this ratio with their respective commissioners.

### 3.3.3 One to one care for all women in active labour

In line with the London Quality Standards, NW London aims to guarantee that women receive one to one care from a midwife in active labour, regardless of their chosen place of birth. By the end of November, this was achieved for 94% of women across the sector, but NW London is aiming for 100% therefore further development is required in this area.

This aggregated percentage disguises variation in performance across the sector. At 98%, Northwick Park Hospital has been consistently achieving the highest 1:1 midwifery cover in labour, which reflects their excellent midwife to birth ratio of 1:27. All other trusts are above the pre-transition average and at 96% or above, with the exception of Imperial Healthcare. At both St Mary’s Hospital and Queen Charlotte’s Hospital the post-transition average has deteriorated from a spot audit done pre-transition, from 91% to 89% and 88% respectively. This data needs to be treated with caution and is likely to be linked to data quality rather than a change in practice. Imperial have now moved to electronic collection of this data and the trust is experiencing data quality issues. The trust is currently revalidating this data.

**Table 5: Percentage of women receiving 1:1 midwifery care in labour**

<table>
<thead>
<tr>
<th>Maternity Unit</th>
<th>Pre-transition</th>
<th>Post-transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte's)</td>
<td>91%</td>
<td>81%</td>
</tr>
<tr>
<td>Imperial (St Mary's)</td>
<td>91%</td>
<td>84%</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td><strong>North West London Average</strong></td>
<td><strong>94%</strong></td>
<td><strong>94%</strong></td>
</tr>
</tbody>
</table>

*Pre-transition data from one spot audit during the year

Source: Maternity Quality Dashboard

It should be noted that this data is notoriously difficult to collect and work should be undertaken to ensure that all trusts are using the same data collection methodology.

**Recommendation 10:** Undertake immediate review of data collection processes with respect to 1:1 midwifery care in labour to ensure consistency of methodology across trusts. Imperial Healthcare Trust need to revalidate their 1:1 care in labour data. Compliance with this should be monitored through their Care Quality Group.
3.3.4 Obstetrics & gynaecology consultant presence on labour ward

The London Quality Standards state that obstetric units should provide 168 hours of consultant presence on delivery wards every week (i.e. 24 hours a day, 7 days a week). Through Shaping a Healthier Future, NW London providers and commissioners committed to delivering the London Quality Standards for maternity although achievement of the full standard was not anticipated immediately upon transition. The benefits case set out an ambition to achieve 123 hours of consultant presence in 2015/16, following transition and NW London is on track to achieve this target. The consolidation in the number of maternity units in July 2015 has enabled significant improvement in this metric across the sector from 101 hours pre-transition, to an average of 122 hours in November 2015. Five of the six trusts in NW London provide more consultant-led care than they previously did. St Mary’s Hospital is the only exception and continues to provide 98 hours per week. Commissioners will work with Imperial Healthcare Trust through contract negotiations, to ensure that this level of cover is improved.

It is worth noting that prior to the transition, Ealing Hospital had a much lower level of consultant presence (60 hours a week) compared to any of its neighbouring trusts. The five obstetrics and gynaecology consultants, who were working at Ealing Hospital at the time of the transition, continue to work within London North West Healthcare Trust, contributing to the improved hours of cover at Northwick Park Hospital.

To provide a complete perspective for clinical cover, it is also important to consider the midwife to birth ratio. The following table analyses the consultant cover at each unit in NW London alongside the current midwife to birth ratio.

<table>
<thead>
<tr>
<th>Maternity Unit</th>
<th>Pre-transition Consultant presence Jul14 - Jun15</th>
<th>Nov-15 Consultant presence</th>
<th>Nov-15 Midwife: birth ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>110</td>
<td>115</td>
<td>1:30</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>96</td>
<td>108</td>
<td>1:31</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte's)</td>
<td>98</td>
<td>116</td>
<td>1:30</td>
</tr>
<tr>
<td>Imperial (St Mary's)</td>
<td>98</td>
<td>98</td>
<td>1:30</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>98</td>
<td>132</td>
<td>1:27</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>146</td>
<td>164</td>
<td>1:32</td>
</tr>
<tr>
<td>Ealing Hospital</td>
<td>60</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>North West London Average</td>
<td>101</td>
<td>122</td>
<td>1:30</td>
</tr>
</tbody>
</table>

Source: Trust Data Returns on Consultant Labour Ward Presence

**Recommendation 11:** Each trust should work with commissioners to finalise plans to further improve clinical cover on labour wards in 2016/17, taking into account any new guidance issued in this area. St Mary’s Hospital needs to increase the consultant presence on labour ward as soon as possible - this needs to be monitored by their Clinical Quality Group.
3.3.5 Quality outcomes
The benefits case set out the following objectives to ensure understanding of quality outcomes:

- to measure clinical outcomes within national metrics

In order to monitor the quality of maternity services in NW London and ensure the intended benefits of the service changes are realised, a set of quality metrics were agreed by the SaHF Clinical Board.

For governance purposes, data is collected from trusts on a monthly basis to produce a report, which is submitted for review and action to the SaHF Clinical Board and the Ealing Quality Committee. The report is also submitted for information to the SaHF Programme Executive, the Implementation Programme Board, Ealing Governing Body and the NW London CCG Quality Committees.

This is a comprehensive set of metrics that enables comparison of performance pre and post transition at individual trust and NW London levels. These are in the context of London Quality Standards and national performance criteria.

The programme intends to continue monitoring these indicators beyond the transition period, through incorporating them into trust quality schedules and therefore into agreed business as usual quality reports.

The full dashboard for December 2015 is given in Appendix 2. Information from the dashboard has been used through this report to evidence the impact of the transition e.g. midwife to birth ratio, 1:1 midwifery care in active labour, breastfeeding initiation rates.

To date the programme has used the dashboards to ensure that standard quality measures such as caesarean section rates, puerperal sepsis have not changed significantly. With only 6 months of post transition data it is too early to identify clear statistical trends. However, it is important that this data continues to be monitored regularly using statistical process control techniques so that any changes in quality of care can be identified promptly.

The programme intends to continue monitoring these indicators beyond the transition period, through incorporating them into trust quality schedules and therefore into agreed business as usual quality reports.

**Good practice learning for future transitions 6**: It is important to establish a clinical outcomes dashboard prior to the transition and use this to monitor quality performance and guide on-going discussions.

**Recommendation 12**: An in-depth analysis of the quality data should be conducted when one year of data is available, to compare to pre-transition data and benchmark against other maternity units in London for measures such as caesarean section rates, assisted deliveries and complications, babies born before arrival, haemorrhage, normal birth, and booking by before 13 weeks.
3.3.6 Maternity unit estate development
In preparation for the transition of maternity services, there was a significant amount of investment in estates across NW London to improve delivery and experience of maternity care.

An extension of the estates at West Middlesex Hospital has resulted in much better facilities for women. A new midwife-led unit has been built, labour ward capacity has been extended and there is new antenatal clinic space. To further improve women’s experience, inpatient en-suite facilities have also been provided.

Imperial Healthcare Trust focused on renovation and making changes to the utilisation of clinical areas. Relocation of the Day Assessment Unit and Maternity Triage at Queen Charlotte’s Hospital created another ward in which to expand the number of postnatal beds. A new Day Assessment Unit has also been developed at St Mary’s Hospital.

At Hillingdon Hospital, part of the delivery ward has been adapted to create a new midwife-led unit, as previously mentioned, and more bespoke work is planned to develop this further in the future. Gynaecology was transferred to another location at the hospital to free up capacity in maternity so that a larger maternity triage area could be developed.

All trusts offer 24 hour access to maternity triage facilities, as they did before the transition, so women can seek clinical advice at any time should they experience any problems.

3.4 Postnatal care
The benefits case set out the following objectives for postnatal care promoting continuity of care:
- choice of setting - care either in home or close to home in the community settings.
- a model of transitional care for babies,
- clear handover protocols and communication with identified healthcare professional for the transition to parenthood,
- enhanced children’s safeguarding through development of provider: borough protocols,
- improved continuity of care for women throughout their antenatal and postnatal pathway.

3.4.1 Redefinition of trust community boundaries
Planning for the transition enabled trusts to come together to redefine their community boundaries, which had previously developed organically. This divided NW London into six areas, one for each of the five trusts and one shared area. These areas were mapped to the units where women choose to deliver. The main aim of undertaking this review of boundaries was to increase the number of women who had continuity of care with the same midwifery team providing their antenatal
and postnatal care. In the five areas associated with a particular trust, there has been much improved clarity about care provision improving women’s care and improving efficiency for staff. Pre transition only 58% of women had all their care provided by the same midwifery team. This redefinition of community areas has meant that post transition 79% of women now have properly integrated antenatal and postnatal care, provided by the same team of midwives.

Figure 3: Trust community boundaries in and around Ealing borough

Women are informed that if they live within the boundary for their chosen trust, midwives come into Ealing to provide clinics so they can have their full pathway of midwifery care delivered at a location close to home. The boundaries do not prevent a woman choosing a different trust and having her care in Ealing, but she may not get that at the children's centre nearest to her home.

The one shared area is between Imperial Healthcare Trust and London North West Healthcare Trust (the hatched area in Figure 6). Whilst this has worked well for the majority of women, challenges have arisen and, although small in number, there have been reports of women contacting units to alert them they have not yet received postnatal care. This area needs to be reviewed and clearly defined areas to be assigned to each trust.
The community midwifery leads continue to meet weekly to review provision of community care and collaboratively decide to refine as required.

3.4.2 Safeguarding
The safeguarding processes and paperwork have been standardised across NW London in partnership with the safeguarding teams to ensure a robust process.

Agreed, standardised community hand over processes and documentation between different community providers and to health visitors following discharge have been implemented across NW London.

**Good practice learning for future transitions 7:** The agreement of a consistent model of care across the network with agreed community catchment areas is instrumental in improving continuity and quality of care for women.

**Recommendation 13:** Continue to review and adjust the community areas to ensure they are aligned with women’s choice of provider so that continuity of antenatal and postnatal care can be provided.

**Recommendation 14:** Review the booking data in the shared area to redefine the trust boundaries so there are no shared areas.

**Recommendation 15:** Continue to monitor compliance with providing continuity of through antenatal and postnatal care.

3.4.3 Care of new-born babies – transitional care
Transitional care units are units where babies who need a little more nursing care and monitoring can stay with their mother rather than being cared for separately in a special care baby unit. This means the mother can be the main carer for her baby. As part of the maternity transition, a model of transitional care has been developed across NW London and is being implemented in all NW London maternity units. This is a major development in clinical care providing considerable benefits to mothers and their babies. There are agreed criteria for transitional care that includes, for example, care for babies requiring intravenous antibiotics, blood sugar measurement, phototherapy or nasogastric tube feeding. The heads of midwifery continue to work together as a network to standardise the clinical model of transitional care and they are working with commissioners to establish an agreed tariff.

3.4.4 Triage, treat and transfer protocols care
Agreed treat and transfer pathways for care were agreed through the transition planning process through the maternity and neonatal networks so that women and babies have streamlined access to specialist services within the sector. The aim is to minimise women and babies having to be transferred out of NW London for tertiary care.
3.4.5 Breastfeeding

The breastfeeding initiation rate has improved post-transition in every unit except Northwick Park Hospital and West Middlesex Hospital, where it has remained the same, as demonstrated in the following table.

Table 7: Breastfeeding initiation rates at each maternity unit

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>89%</td>
<td>97%</td>
<td>90%</td>
<td>88%</td>
<td>89%</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>84%</td>
<td>86%</td>
<td>86%</td>
<td>87%</td>
<td>87%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte’s)</td>
<td>83%</td>
<td>93%</td>
<td>90%</td>
<td>91%</td>
<td>93%</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Imperial (St Mary’s)</td>
<td>87%</td>
<td>96%</td>
<td>95%</td>
<td>90%</td>
<td>98%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>85%</td>
<td>83%</td>
<td>86%</td>
<td>85%</td>
<td>85%</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>90%</td>
<td>93%</td>
<td>91%</td>
<td>88%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Source: Maternity Quality Dashboard

The most marked improvement has been at Queen Charlotte’s Hospital and St Mary’s Hospital, where they have recently introduced a community breastfeeding support service. Hillingdon Hospital has also recently created a new infant feeding coordinator role, which it is anticipated will help them to further improve in this area.

3.4.6 Perinatal mental health

In planning for the transition it was agreed to develop a new model of care for perinatal mental health in NW London. A community perinatal mental health service to ensure comprehensive and coordinated care is being piloted in Ealing, Hounslow and Hammersmith and Fulham. The team includes a consultant psychiatrist, a psychologist, two mental health nurses and an administrative assistant. The service is aligned to existing midwifery and health visiting services. This represents a major investment in this important area and one from which key learning should be extrapolated and spread.

**Recommendation 16:** Confirm and fully commission an agreed model of transitional care across NW London with an agreed tariff. The impact of this on neonatal admissions and length of stay should be actively monitored.

**Recommendation 17:** Review the impact of the perinatal mental health pilot and spread learning through NW London.
Chapter 4: Demand on maternity services

The benefits case set out the following objectives in relation to capacity to promote choice:

- sufficient maternity delivery capacity in NW London

During planning for the transition, NW London clinicians developed a bed model and an Ealing allocation model, to test trust capacity plans. The bed model showed that compared to 2011/12, when units experienced a peak in birth activity yet managed their own maternity services, NW London planned to have more beds to handle the fewer deliveries forecast in 2015/16. The Ealing allocation model looked at six different ways (allocations) of understanding where the women currently choosing Ealing Hospital may choose to go based on historic activity, proximity to sites, GP preferences and women’s preferences. NW London clinicians (SaHF Clinical Board) agreed a weighting of these based on confidence in the different allocations to use as the best available predictor of where women would choose to go.

Based on these models, the maternity units across NW London planned shared capacity for an additional 3,000 deliveries from Ealing Hospital per annum, 500 more than the 2,500 that previously delivered at the unit. This ensured that the model of care is sustainable and allows for potential future population increases.

4.1 Bookings and deliveries activity

There are approximately 36,000 bookings and 30,000 deliveries in North West London each year. Monthly monitoring of these levels since April 2014 has shown no change in trends since the transition of maternity services in July 2015, with an average of 3,000 bookings and 2,500 deliveries per month.

Figure 4: Number of monthly bookings and deliveries in NW London

Source: Maternity Quality Dashboard
Fewer deliveries were originally forecast in 2015/16, but the actual number is set to rise by 1% compared to 2014/15 as demonstrated in the following table.

Table 8: Total number of deliveries in NW London since 2011/12

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Total Number of Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>31,600</td>
</tr>
<tr>
<td>2012/13</td>
<td>30,700</td>
</tr>
<tr>
<td>2013/14</td>
<td>29,600</td>
</tr>
<tr>
<td>2014/15</td>
<td>29,800</td>
</tr>
<tr>
<td>2015/16 (forecast)</td>
<td>30,100</td>
</tr>
</tbody>
</table>

Source: SUS data

Just under half of the forecast increase in 2015/16 is due to a net increase from out of sector flows, with more women from outside the sector choosing to deliver in NW London than those who choose to leave. The remaining increase is due to a rise in the birth rate, mainly in Hounslow (6% increase) and Brent (4% increase), although notably, the birth rate in Ealing is forecast to fall by 284 (5%) in 2015/16. The rise in number of deliveries is within the contingency that was built into the new model to accept 500 additional births per annum across the sector.

4.2 Actual versus planned activity for each maternity unit

Based on the modelling and the trust assurance plans, the annual additional maternity activity from Ealing Hospital that each receiving trust can manage following the transition was agreed and is detailed in the figure below.

Figure 5: Summary of agreed annual additional maternity activity receiving trusts can safely support upon closure of Ealing Hospital maternity unit

Source: Maternity Model of Care
To assess the robustness of the activity modelling, the actual change in deliveries inNW London maternity units has been estimated using trust data provided to monitor the maternity transition.

- The pattern of Ealing deliveries between 2013/14 and 2014/15 was compared to establish a baseline data set. There were no major changes in the provider shares of deliveries by women from Ealing in the lead up to the transition, therefore the latest full year of actual delivery data from 2014/15 was used as a baseline for analysis,
- delivery activity data for the five months following transition (July - November 2015) was compared to the same months in 2013 and 2014 to determine if the activity level has changed from the baseline.
- using a factor that takes account of historic seasonal patterns in delivery, the change at each unit for July to November 2015 was used to forecast the annual activity expected at each unit following the transition,
- service (SUS) data was used to identify activity relating to:
  - women registered with Ealing CCG GP practices
  - women registered with other NW London GP practices
  - activity flows from outside of the NW London sector
- the forecast annual change is compared with planned changes and capacity.

In 2015/16, 86.3% of women who would have previously delivered at Ealing Hospital, but have now delivered at another maternity unit, were registered with a GP in Ealing CCG. Change in delivery activity from Ealing CCG at the other maternity units in 2015/16 was therefore extrapolated to represent the total change in activity attributable to the closure of inpatient services at Ealing Hospital. This assumed that the remaining 13.7% of activity from other NW London CCGs or outside of the sector followed the same distribution pattern as the Ealing CCG activity.

The following graph shows where the activity from Ealing Hospital has moved following the transition. Ealing Hospital still had 470 deliveries in 2015/16; therefore 2016/17 is the first year to forecast a full year’s distribution of activity. These activity flows are an estimate based on current activity levels and it should be recognised that anticipated flows may continue to change until the model of care is more embedded.
**Figure 6: Forecast activity from Ealing Hospital in 2015/16 and 2016/17 compared to planned**

*When Ealing Hospital maternity unit was in operation, Ealing women still chose to give birth at other units. This graph indicates that fewer women are choosing to go to St Marys after the transition than did previously.*

Source: SUS data

This graph shows that no maternity unit is forecast to exceed the planned additional activity expected from Ealing Hospital. This is most likely due to the fact that a contingency of 500 additional births was factored into the modelling. The activity most aligned to the modelling is Northwick Park Hospital, which is expected to receive 96% of its 250 planned additional births in 2016/17. Hillingdon Hospital and West Middlesex Hospital are also expected to receive close to planned activity with 91% and 87% respectively. Imperial however, was projected to receive a lot more activity than has been demonstrated because Queen Charlotte’s Hospital is only receiving 76% of planned activity and fewer women who live in Ealing are choosing to give birth at St Mary’s Hospital since the transition than were using the unit before Ealing Hospital closed. Chelsea and Westminster Hospital has also had a very marginal increase in the number of women who would have previously delivered at Ealing Hospital, equating to an additional two to three deliveries a month or 9% of planned additional activity. This change for Chelsea and Westminster Hospital was expected as women were anticipated to be redirected from areas of Hammersmith & Fulham to Chelsea and Westminster Hospital, to release capacity at Queen Charlotte’s Hospital, rather than redirecting women from Ealing.

While the closure of inpatient maternity services at Ealing was the biggest change in the system, there have also been other factors which have affected the distribution of activity across the system. The following table shows the forecast activity change from 2014/15 to 2015/16 and 2016/17 from all sources when compared to the planned additional activity from Ealing Hospital.
This data shows that all units in NW London are forecast to have an increase in the number of deliveries in 2015/16 and 2016/17. This is in part due to the forecasted increase in the number of deliveries in NW London to 30,100. While no units are expected to receive more activity than was planned from Ealing Hospital, Northwick Park Hospital and West Middlesex Hospital are expected to receive a significant amount of additional activity from elsewhere in the system.

In addition to receiving 96% of their planned activity from Ealing Hospital (202 deliveries), Northwick Park Hospital has actually seen a bigger rise in the number of deliveries from Brent. Deliveries from this borough have increased by 4%. This means that the unit has exceeded the maximum increase of 250 additional births requested by commissioners in response to the Care Quality Commission report in 2014 (where maternity care at Northwick Park Hospital received a “Requires Improvement” rating). Without intervention this will lead to a forecast annual delivery rate of 5,330, which is above the maximum annual capacity for the unit. This needs to be considered within the context that Northwick Park is delivering a safe service for these mothers and babies, the unit has the best midwife to birth ratio in the sector and monitoring through the maternity dashboard indicates that the unit is currently

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### Table 9: Forecast activity change from all sources compared to planned additional activity from Ealing Hospital

<table>
<thead>
<tr>
<th>Maternity Unit</th>
<th>Baseline activity 2014/15</th>
<th>Planned additional activity</th>
<th>Maximum annual capacity</th>
<th>Forecasted activity 2015/16</th>
<th>Forecasted change 2015/16</th>
<th>Forecasted activity 2016/17</th>
<th>Forecasted change 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ealing</td>
<td>2521</td>
<td>0</td>
<td>0</td>
<td>470</td>
<td>-2051</td>
<td>0</td>
<td>-2521</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>5150</td>
<td>350</td>
<td>6000</td>
<td>5250</td>
<td>100</td>
<td>5270</td>
<td>120</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>4143</td>
<td>800</td>
<td>5000</td>
<td>4762</td>
<td>619</td>
<td>4882</td>
<td>739</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte’s)</td>
<td>4977</td>
<td>800</td>
<td>6000</td>
<td>5525</td>
<td>548</td>
<td>5631</td>
<td>654</td>
</tr>
<tr>
<td>Imperial (St Mary’s)</td>
<td>3610</td>
<td>200</td>
<td>4000</td>
<td>3693</td>
<td>83</td>
<td>3709</td>
<td>90</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>4827</td>
<td>250</td>
<td>5300</td>
<td>5251</td>
<td>424</td>
<td>5333</td>
<td>506</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>4524</td>
<td>600</td>
<td>5500</td>
<td>5181</td>
<td>657</td>
<td>5308</td>
<td>784</td>
</tr>
<tr>
<td><strong>NWL unit total</strong></td>
<td><strong>29752</strong></td>
<td><strong>500</strong></td>
<td><strong>31800</strong></td>
<td><strong>30132</strong></td>
<td><strong>380</strong></td>
<td><strong>30133</strong></td>
<td><strong>381</strong></td>
</tr>
</tbody>
</table>

### Table 10: Understanding the composition of the change from actual 2014/15 activity to forecast 2015/16 activity

<table>
<thead>
<tr>
<th>Maternity Unit</th>
<th>Baseline activity 2014/15</th>
<th>Forecasted activity 2015/16</th>
<th>Change in activity</th>
<th>Change in activity by CCG</th>
<th>Other NW London CCGs</th>
<th>Out of sector CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ealing</td>
<td>2521</td>
<td>470</td>
<td>-2051</td>
<td>-1771</td>
<td>-173</td>
<td>-107</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>5150</td>
<td>5250</td>
<td>100</td>
<td>23</td>
<td>59</td>
<td>18</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>4143</td>
<td>4762</td>
<td>619</td>
<td>524</td>
<td>-136</td>
<td>231</td>
</tr>
<tr>
<td>Imperial (Queen Charlotte’s)</td>
<td>4977</td>
<td>5525</td>
<td>548</td>
<td>438</td>
<td>69</td>
<td>41</td>
</tr>
<tr>
<td>Imperial (St Mary’s)</td>
<td>3610</td>
<td>3693</td>
<td>83</td>
<td>-37</td>
<td>104</td>
<td>15</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>4827</td>
<td>5251</td>
<td>424</td>
<td>174</td>
<td>231</td>
<td>18</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>4524</td>
<td>5181</td>
<td>657</td>
<td>378</td>
<td>251</td>
<td>28</td>
</tr>
<tr>
<td>Other providers</td>
<td>-</td>
<td>-</td>
<td>73</td>
<td>-13</td>
<td>86</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29752</strong></td>
<td><strong>30132</strong></td>
<td><strong>380</strong></td>
<td><strong>-271</strong></td>
<td><strong>405</strong></td>
<td><strong>244</strong></td>
</tr>
</tbody>
</table>

Source: SUS data
meeting the quality metrics for maternity. A review of the capacity at Northwick Park Hospital needs to be undertaken in partnership with the CCG, provider and SaHF to understand the provider’s plans for growth. There is capacity in neighbouring trusts and community areas could be further adjusted to support more women from Brent choosing to have their babies at St Mary’s Hospital, if this is the approach agreed upon.

The majority of additional activity at West Middlesex Hospital is from Ealing Hospital but it has also seen a significant rise in the number of deliveries from Hounslow, which has also demonstrated a growth in birth rate (6%). Unlike NPH, West Middlesex Hospital is expected to remain within its maximum annual capacity of 5,500 with a forecast annual delivery rate of 5,310 in 2016/17.

Hillingdon Hospital’s biggest rise in activity is from Ealing, but it is also forecast to receive an additional 276 deliveries in 2016/17 from out of sector. This is balanced by a large fall in the number of women choosing the unit from other NW London CCGs, so the unit is forecast to have activity of 4,882 in 2016/17, which is within the unit’s capacity of 5,000 deliveries. The rise in out of sector activity may reflect an increased number of women choosing Hillingdon Hospital over neighbouring out of sector units that had been rated as ‘inadequate’ by the Care Quality Commission at Watford General Hospital and Wexham Park Hospital. A recent Care Quality Commission review of Wexham Park in October 2015 however, rated the service as ‘good’, which, if this is a factor in women’s choice, may impact activity numbers in future months.

Queen Charlotte’s Hospital also took the majority of its activity increase from Ealing Hospital, but much less than expected and it has seen had little change in activity from elsewhere. Alongside Chelsea and Westminster Hospital and St Mary’s Hospital, which have only had a small increase in activity, these units have significant additional available capacity.

**Good practice learning for future transitions 8:** A cautious activity model building extra capacity into the system, facilitated women’s choice following the transition and built in resilience. Once the system stabilises this additional capacity can be reviewed.

**Recommendation 18:** An urgent review of capacity and catchment areas at Northwick Park Hospital is required to address the forecasted rise in activity beyond the expectations of commissioners and the unit’s capacity.

**Recommendation 19:** Continue to monitor activity at the other maternity units, particularly as the changes to the trust catchment areas embed, to ensure there are no issues with capacity.
4.3 Comparison of delivery activity within trust catchment areas

A further analysis was conducted to determine whether the new trust catchment areas in Ealing are matched to the main providers for deliveries in each postcode area of Ealing borough.

Figure 7: The ten postcode areas in Ealing Borough

Source: Shaping a Healthier Future Ealing Postcode Map

Table 11: Top providers for deliveries in 2015/16 compared to trust catchment areas for each postcode area

<table>
<thead>
<tr>
<th>Ealing Postcode</th>
<th>Postcode Trust Catchment areas</th>
<th>Top 3 providers for delivery in 2015/16</th>
<th>Provider %</th>
<th>Provider %</th>
<th>Provider %</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW10</td>
<td>ICHT, NWP</td>
<td>ICHT</td>
<td>66%</td>
<td>NWP</td>
<td>24%</td>
</tr>
<tr>
<td>UB1</td>
<td>THH, WMUH, ICHT, NWP</td>
<td>THH</td>
<td>52%</td>
<td>NWP</td>
<td>19%</td>
</tr>
<tr>
<td>UB2</td>
<td>WMUH, ICHT, NWP</td>
<td>WMUH</td>
<td>39%</td>
<td>THH</td>
<td>30%</td>
</tr>
<tr>
<td>UB5</td>
<td>THH, NWP, ICHT</td>
<td>ICHT</td>
<td>36%</td>
<td>NWP</td>
<td>32%</td>
</tr>
<tr>
<td>UB6</td>
<td>THH, NWP, ICHT</td>
<td>ICHT</td>
<td>49%</td>
<td>NWP</td>
<td>31%</td>
</tr>
<tr>
<td>W3</td>
<td>ICHT</td>
<td>ICHT</td>
<td>91%</td>
<td>CWHFT</td>
<td>5%</td>
</tr>
<tr>
<td>W4</td>
<td>ICHT, CWHFT</td>
<td>ICHT</td>
<td>63%</td>
<td>CWHFT</td>
<td>23%</td>
</tr>
<tr>
<td>W5</td>
<td>ICHT, WMUH</td>
<td>ICHT</td>
<td>77%</td>
<td>WMUH</td>
<td>13%</td>
</tr>
<tr>
<td>W7</td>
<td>WMUH, ICHT</td>
<td>ICHT</td>
<td>59%</td>
<td>WMUH</td>
<td>19%</td>
</tr>
<tr>
<td>W13</td>
<td>ICHT, WMUH</td>
<td>ICHT</td>
<td>66%</td>
<td>WMUH</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: SUS data

On the whole, the delivery activity forecast in 2015/16 equates to the trust catchment areas for each postcode in Ealing. However, Hillingdon Hospital provides 30% of deliveries for the UB2 postcode but UB2 is not in the trust’s catchment area. Whilst these women are still able to access their care from Hillingdon Hospital it would be helpful to review catchment areas for this area to align to women’s choice. This action is captured under recommendation 13.
Chapter 5: Interdependent services

5.1 Neonatal service transition

The benefits case set out the following objectives for neonatal care, promoting choice and access:

- Ensure sufficient cot capacity in NW London
- Develop a model for transitional care for babies

The neonatal unit at Ealing Hospital closed two days before the maternity unit, on 29 June 2015. There were no babies in the unit at the time that required transfer and the unit closed safely. The key objective of the new neonatal model of care was to ensure all babies needing on-going neonatal care have rapid access to the appropriate level of care as close to home as possible. Key elements include:

- a specialist neonatal transport service (this was an existing service)
- established care pathways that allow mothers and babies to rapidly access a unit offering the appropriate level of neonatal care
- adequate assessment of need and provision of appropriate capacity
- development and standardisation of transitional care (see 3.4.3)

5.1.1 Neonatal demand and capacity

With the exception of Ealing Hospital, the number of neonatal unit admissions across the sector has been gradually increasing each year since 2012. The following graph shows the annual change in the numbers by trust.
The majority of babies admitted to the neonatal units in NW London are from the area and this percentage has remained constant over the last two years (92-94%), therefore a rise in the number of babies from outside NW London does not account for the increase. While there has been an increase in the extremely preterm babies admitted to neonatal units in NW London, the majority of the increase in admissions is due to the increase in the numbers of babies admitted at term. This follows a national trend in increasing term admissions reported by NHS England.

Further analysis of the local data was performed to compare the monthly admission numbers for each unit post-transition with the baseline monthly average (July 2014 - June 2015 data). This shows the total number of admissions across the sector following the transition has consistently been higher than the baseline, although this is variable.

Table 12: Number of neonatal unit admissions by trust following the Ealing transition

<table>
<thead>
<tr>
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<td><strong>269</strong></td>
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Source: Acute Trust Badgernet Database
Activity in the Special Care Baby Units has increased in NW London and this is particularly evident in three units – Hillingdon Hospital, West Middlesex Hospital and Northwick Park Hospital. The increase in activity at Hillingdon Hospital and West Middlesex Hospital can be accounted for by the increase in deliveries following the closure of inpatient services at Ealing Hospital. However, the increase at Northwick Park Hospital does not completely equate to the rise in activity. Northwick Park Hospital is currently reviewing all admissions to establish the cause for this increase. These three units do not yet have an embedded transitional care service which could be adding to the increase in neonatal admissions. The model of transitional care is being standardised in NW London and a tariff is being agreed, the services are at different stages of implementation and using different clinical models currently, standardisation of this needs to occur. Overall the network data does not suggest that the length of stay has increased at any of the neonatal units.

Additional physical capacity of fifteen neonatal cots was put in place in the receiving trusts for the transition, which includes the cots reassigned from Ealing Hospital. All of these were SCBU cots; there was no increase in intensive care or high dependency cots. This is in line with the type of neonatal activity at Ealing Hospital. The Neonatal Network share demand management approaches between trusts, which has been further supported by the merger of Chelsea and Westminster Hospital and West Middlesex Hospital at the end of 2015. There is good communication between the neonatal units in the Network to refer babies both for intensive care and also to transfer babies back to local hospitals for continuing care. The following table compares the average number of monthly neonatal transfers pre-transition with post-transition, both within NW London and outside the Network.

<table>
<thead>
<tr>
<th>Type of transfer</th>
<th>Location of transfer</th>
<th>Pre-transition monthly average (Jan - Jun 2015)</th>
<th>Post-transition monthly average (Jul - Dec 2015)</th>
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<tr>
<td>In Utero Transfer</td>
<td>Transfer within NWL</td>
<td>0.8</td>
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<tr>
<td></td>
<td>Transfer to another Network</td>
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<td>1.2</td>
</tr>
<tr>
<td>Postnatal Transfer</td>
<td>Transfer within NWL</td>
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</tr>
<tr>
<td></td>
<td>Transfer to another Network</td>
<td>1.3</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Source: NHS England

While the average numbers of transfers within NW London have not changed following the transition, there has been an increase in transfers within the network due to lack of intensive care capacity. Transfers to other networks are also normally due to lack of intensive care capacity and the number of babies transferred postnatally to another network has increased since the transition. This has been due to a lack of specialist cots for babies with surgical problems. Chelsea and Westminster Hospital is the provider of surgical cots and they are currently reviewing and auditing this increase in demand with a plan to increase their intensive care cot capacity for babies requiring surgical management.

Ealing Hospital did not previously provide intensive care capacity or surgical cots in its neonatal unit; therefore this increase in demand is unrelated to the transfer.
5.1.2 Neonatal workforce
All twelve of the neonatal nurses working at Ealing Hospital were able to transfer to their first choice of hospital and were fully supported with the changes. The clinical lead nurse for the transition had one-to-one meetings with all of them, both formal and informal, and all receiving units were reported to be very welcoming. All of the neonatal nurses who transitioned are still in post. Feedback to the clinical lead has been that they are all settling in really well in their new positions.

**Recommendation 20:** A neonatal nurse focus group should be organised to obtain feedback from this staff group about their experience of the transition.

5.2 Emergency gynaecology service at Ealing Hospital

The benefits case set out the following objectives for gynaecology services in relation to maternity care:

- access to 24-hour maternity triage and emergency gynaecology services for women should problems occur:

Gynaecology services were interdependent with the maternity service at the Ealing Hospital site before the maternity transition due to shared medical staffing and activity from pregnancy related conditions. Following the transition, Ealing Hospital continues to provide elective inpatient and outpatient gynaecology services on-site as before. It also provides a new model of emergency gynaecology services to support the emergency department at Ealing Hospital and ensure continuity of care for women in the local area. The key aspects of the new emergency gynaecology model of care are:

- enhanced gynaecology emergency clinic in the core hours during the week, which includes an Early Pregnancy Assessment Unit,
- introduction of a gynaecology emergency clinic at the weekend,
- improved middle grade medical cover at Ealing hospital for emergency gynaecology patients,
- consultant cover for gynaecology emergencies: in hours, onsite and out of hours from Northwick Park Hospital.

The new model aims to deliver a better service to the local population, support the emergency department and avoid putting pressure on nearby trusts by preventing them from having additional emergency attendances and admissions. The following table shows the number of attendances at early pregnancy assessment Units across NW London.
The average number of attendances at early pregnancy assessment Units appears to have increased at every unit, including Ealing Hospital, following the transition, except Hillingdon Hospital. There has been a significant increase at Northwick Park Hospital (>100 cases per month), which is more than would be anticipated relative to their increase in delivery activity when compared to the other trusts, especially as there has also been an increase at the other London North West Healthcare Trust site at Ealing Hospital. There has been a significant increase at St Mary’s Hospital, which their gynaecology consultants believe is due to the direct access to early pregnancy assessment unit from A&E at this site. At Imperial's other site at Queen Charlotte's Hospital, the women is referred on to early pregnancy assessment unit from the Urgent Care Centre or their GP.

Table 14: Early Pregnancy Assessment Unit activity at sites across NW London

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<td><strong>3380</strong></td>
<td><strong>2977</strong></td>
<td><strong>3394</strong></td>
<td><strong>3555</strong></td>
<td><strong>3016</strong></td>
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</tbody>
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Source: Trust EPAU data
Chapter 6: Women's experience

As part of this review a postal survey was conducted to evaluate the experience of mothers and mothers-to-be whose care was moved from Ealing Hospital as a result of the transition. Membership Engagement Services (MES) was commissioned to design, issue and report on findings. The survey was co-designed with lay partners and the SaHF Travel Advisory Group to solicit feedback about information and materials, travel to access care and overall experiences of care throughout the transition. Details of the complete survey can be found in Appendix 4.

778 postal surveys, covering letters and Freepost reply envelopes were prepared by MES and despatched directly from London North West Healthcare NHS Trust. Postal surveys were supplemented by visiting two children’s centres in North West London where additional surveys were conducted face-to-face. There were 103 responses collected (13% response rate), which is higher than would be anticipated for a survey of this type. The spread of responses for each maternity unit was representative of the number of women who were transferred to the units.

6.1 Information and materials

Overall, 76% of participants indicated they were given information about other hospitals and travel, with the highest level of response seen among those whose care was moved to Queen Charlotte’s Hospital (90%). Of those who had been given information, the highest proportion cited receiving the ‘Giving birth’ booklet (64%) followed by a letter (50%) and bus map (47%). Around a quarter (24%) of participants noted receiving the ‘giving birth’ easy read booklet, and this figure was highest among participants for West Middlesex Hospital (33%).

Image 1 – Giving Birth Booklet, Image 2 – Easy Read Booklet, Image 3 – Bus Map

The majority of women (63%) received this information by post, or their midwife (44%), and significantly fewer noted receiving this at a GP practice (5%) or children’s centre (4%). Those who moved to Queen Charlotte’s Hospital were least likely to receive information from a midwife, with just over a quarter having done so.

Nearly three quarters of participants felt that they had enough information about other hospitals where they could choose to give birth (72%) and travel (74%) compared to 13% who disagreed. Participants were able to indicate what additional information would have been useful. Around a third of participants (35) provided a
free-text response for this question, and one in six of these took the opportunity to reiterate they felt they had enough information. Around one in four indicated they had enough information, but this may have been things they already knew, heard via word-of-mouth or researched themselves. Nearly a third of these 35 respondents cited a desire for more travel information such as parking and travel by car and maps including how to get around the hospitals themselves. A similar proportion of responses would have liked more information about hospitals they could access including quality and range of services.

6.2 Travel to access care

Overall, less than half of participants (45%) said their midwife asked them about their travel plans to the hospital where they were moved, a slightly higher proportion than those who were not asked about their plans (41%). However, more women at Queen Charlotte’s Hospital (48%) and West Middlesex Hospital (48%) were not asked.

The largest proportion of participants received their antenatal and postnatal care at a hospital (77%). Around a third received care at a children’s centre or health centre (37%) or at home (34%). When asked if the transition had made it harder for them to attend their appointments on time, the majority of participants disagreed with this statement or indicated it made no difference: 68% for antenatal and postnatal appointments and 69% for hospital-based appointments. This compared to the quarter of participants who felt less able to get to these appointments on time following the transition.

Participants had the opportunity to describe any other travel difficulties they had experienced after their maternity care was moved to another hospital. Just 17 participants provided a free text response to this question. A key theme among comments received was the longer journey time to access maternity care.

6.3 Overall experience of care

Overall, a majority (59%) of participants felt supported during the transition, however 26% indicated that they did not feel supported, highlighting the complexity of the transition. Once under the care of their new units most women (79%) were happy with the care that they received. Most respondents gave reasons for this with half citing staff as a key reason for their satisfaction; key themes included friendly, respect, care and support.

6.4 Experience of women living in Southall

Ensuring a positive experience for the women of Southall has been a key area of focus within the transition especially in relation to communications and travel. 33 women from Southall completed the experience survey, 1/3 of all respondents, enabling insight to be gained as to whether these women had a positive experience.
Under the care of their new units most women (75%) were happy with the care that they received and this is comparable to all women who underwent the transition. In relation to information, 75% agreed they had received enough information about other hospitals where they could choose to give birth and 78% indicated they received enough information about travel.

When asked if the transition had made it harder for them to get to their hospital appointments, the responses were similar to the experience of women in general. However a larger percentage of women indicated that it had become harder for them to attend their antenatal/postnatal appointments on time, 36% compared to 19% of the overall survey respondents. This could be driven by the fact that only 28% of the Southall women indicated that they received antenatal or postnatal care from a children’s centre or health centre. It is recommended that midwives and the CGG work with GPs and women in this area to assure them that high quality antenatal and postnatal care can be received locally and that it will be delivered by the same team of midwives who deliver their baby in hospital.

**Good practice learning for future transitions 9:** A comprehensive set of information material, developed with lay partners, brought together information on maternity care across NW London for the first time, facilitated women’s choices and was well received.

**Recommendation 21:** Ensure further communications are provided to women in relation to their choice of antenatal and postnatal care, especially within the borough of Ealing.
Chapter 7: Staff experience

7.1 Approach to staff transition

When transitioning staff and building the workforce at each of the receiving units there were two significant priorities:

1. to retain the skills and knowledge within the sector
2. to increase the number of midwives in NW London (to improve midwifery to birth ratios and ensure 1:1 care for women in active labour)

To do this, a ‘no redundancies’ approach was developed. All staff were offered opportunities for redeployment in NW London and moved across to receiving units via the TUPE\(^1\) process. There were no resignations as a result of the transition. In the vast majority of cases, staff were able to transfer to their trust of choice.

Any transition is challenging and the timing of the maternity transition was particularly so. Predictably, a change to the date in transition and short period of time to transfer had a negative impact on staff morale. To help support staff at this time of uncertainty, retention bonuses were paid to staff. In addition, Health Education England North West London provided significant training bursaries for each of the transferring members of staff. The retention of staff over the transition period as well as the recruitment of new midwives is a testament to the calibre of midwives themselves, management by the trusts in NW London and validity of the workforce transition approach.

At the time of the transition there were 88 midwives working at Ealing Hospital who were transferred to the other maternity units in the sector, resulting in an initial reduction in the vacancy rates at the receiving trusts. A collaborative approach was taken by the trusts to ensure there was no ‘poaching’ of staff which could have risked destabilisation of the workforce in the sector. Furthermore, there was a concerted drive to recruit additional midwives to NW London in preparation for the transition, which resulted in an increase of almost 100 whole time equivalent midwives from 840 in February 2015 to 939 in December 2015.

There have been eight midwives from Ealing who have left their posts since the transition. Two were due to retirement, two to work closer to home, one due to ill health and one to take up an opportunity to work as an independent midwife.

Vacancy rates in nursing, midwifery and general medical staff continue to be a national problem for the NHS. However, the coordinated focus on recruitment and

\(^1\) When TUPE applies, the employees of the outgoing employer automatically become employees of the incoming employer at the point of transfer. They carry with them their continuous service from the outgoing employer, and should continue to enjoy the same terms and conditions of employment with the incoming employer.

Following a transfer, employers often find they have employees with different terms and conditions working alongside each other and wish to change/harmonise terms and conditions. However, TUPE protects against change/harmonisation for an indefinite period if the sole or principal reason for the change is the transfer.
retention through this transition not only maintained staff from Ealing Hospital, but made significant improvements in reducing vacancy rates in NW London as a sector.

**Good practice learning for future transitions 10:** Additional staff retention and development packages helped retain staff through an unsettling time.

**Good practice learning for future transitions 11:** A coordinated, sector-wide approach to recruitment with agreed principles of not encouraging staff to move between units had significant impact on vacancy levels.

### 7.2 Clinical leadership

A strong network of dedicated clinical leaders emerged from the transition to drive quality and consistency of care for women. Clinical leadership and the strengthening of relationships across NW London has been a real benefit of the service transition. In the past the heads of midwifery did come together occasionally for workshops and professional development, but the transition required them to meet regularly to make decisions, gain consensus and agree implementation of changes across the sector. The strong relationships that were forged during this time have continued and now extend into other forums, including the London Strategic Network. This has enabled them to inform commissioning standards together, so they are the same across the sector, and there is now a good relationship and a direct clinical link with the lead nurse clinical commissioners. This collaboration and knowledge sharing is driving up the quality and consistency of care for women.

The community midwifery leads continue to meet weekly to review provision of community care and refine as required. An additional benefit has been the opportunity to work on other projects to improve care delivery, for example, working towards electronic discharge arrangements.

**Good practice learning for future transitions 12:** This was a clinically-led transition with good engagement from all providers and commissioners, supported by a strong programme management approach. This was key to the success of the transition and the benefits of the strong clinical network continue to be realised beyond transition.

### 7.3 Midwifery staff

Focus groups were conducted in January 2016 to obtain feedback on midwives’ experience of the transition and inform future service changes. Membership Engagement Services, a communications and research agency that specialises in public and member engagement in the healthcare sector, was commissioned to design, run and report on findings from the focus groups. The key objective was to obtain midwives’ views on the transition and its impact on maternity care in the area. It is worth noting that this was a small-scale study and therefore care must be taken in interpretation of the findings as those who participated may not necessarily be representative of their maternity unit or of maternity staff as a whole.
Focus groups were held at five of the six receiving hospitals in North West London. Hillingdon Hospital was the only maternity unit which was not able to hold a focus group as they were unable to release staff. Overall, there were 29 participants, which included midwives transferred from Ealing, receiving staff, community-based midwives and trainees. All were recruited to take part by heads of midwifery at each unit.

7.3.1 Midwifery experience of the transition
Most participants did not find the transition straightforward, with the main issues mentioned being the uncertainty over the closure of Ealing hospital and the perceived shortness of the timetable to closure once the decision was announced. The majority of midwives from Ealing felt the speed of the transition with short notice of the closure date caused additional rush and stress.

Participants’ views on the communications they had received varied widely. Some were aware of many channels, while others mentioned only one or two. Others said they had never received personal communication about the changes, although also acknowledged that they may not have been receptive at that stage so communications may have gone unnoticed. To some extent, their view of the efficacy of the communications was tainted by the uncertainty over the closure: in the absence of concrete information some ‘tuned out’. Overall, there was a divide among these midwives on whether the communication was as effective as it could have been, given the uncertainties of the situation in the run-up to the closure.

Among the participating midwives, the extent to which the transition affected travel arrangements varied. Some lived close to the hospital they joined and so their journey was much shorter than to Ealing, while others had gone from being a short walk to Ealing hospital to two hours’ travel a day. It is not possible from this exercise to say what the overall effect on all midwives’ travel arrangements has been. Other issues mentioned were paying for car park permits and the lack of pool cars, while the practical issues of claiming for travel costs were sometimes complicated by the lack of knowledge among human resources.

**Recommendation 22:** The uncertainty about the decision to implement the maternity and neonatal transition had a negative impact on staff experience and engagement in the changes. Decisions for future changes need to be made further in advance of implementation, to prepare staff.

**Recommendation 23:** Trusts need to ensure an effective route in communicating with their staff. This needs to be coordinated by an accountable individual to prevent mixed messages, rumours, and disengagement.

7.3.2 Midwifery experience of the new maternity units
At the time of the research, six months following the transition, the majority of those who had moved from Ealing had settled-in well, having been welcomed and well-supported by the receiving staff. The receiving unit staff were delighted to gain new and sometimes very experienced staff. Feeling integrated and fully up-to-speed could, however, take new joiners some months. Not all of those interviewed were as
content however, with mentions of a ‘them and us’ mentality at St Mary’s Hospital and West Middlesex Hospital and at least one joining staff member at the latter hospital feeling isolated and requesting more support. It is important that comments such as these are captured and acted on but they represent a small part of a successful workforce transition.

A mixed picture also emerged from the participants concerning the buddy system and orientation days i.e. some were aware and experienced them but sometimes the workload simply meant that allocating a buddy or allowing staff on orientation days just to observe, was not possible. Sometimes orientation days could be so far ahead of the individual’s move across that they felt they had forgotten much of what they had learned by the time they began work at their new hospital.

In addition, the day-to-day changes in the systems they would be working with were not always well-addressed. Many participants struggled with the differences in the computer systems at their new hospitals and some mentioned that training on these systems was not available at the right time.

**Good practice learning 13:** Senior grades need more support to settle into new positions, especially if there is a significant change in their role. Senior midwives changed from being largely administrative at Ealing, to more clinical roles at the receiving trusts, which some found challenging.

**7.3.3 Midwifery experience of workload and quality of care**
Both joiners and receivers at some hospitals commented on the increase in workload, with this issue being particularly prevalent among community-based staff. While the receiving hospitals had obviously gained more staff, the staff were given the choice of which clinical area they wanted to go to and this left some community areas relatively short staffed.

The receiving hospitals were felt to have found absorbing the extra staff quite easy, not least because of prior staff shortages. There was less agreement on how well the extra patients had been absorbed, with staff at three out of five of the hospitals expressing varying levels of concern and more generally a sense that midwives have to cope with a greater workload post-transition. At almost all the hospitals some issues were raised about whether the facilities were sufficient and there were concerns about a lack of IT facilities in the community sites.

The majority of participating midwives did not feel that care had improved as a result of the changes. Going from seven hospitals to six did not address the perceived difficulty in recruiting and retaining midwives. There was a sense at some hospitals that there was still not the correct balance between extra staff and additional patients. There was a view that care was less personal; clinics at hospitals and in the community were under pressure and patients experienced long waits, however the midwives felt they were coping at present. Only at one hospital (Queen Charlotte’s Hospital) was there any mention of benefits arising from the transition which was additional staffing, improved community boundaries and improved estates.
These expressed views do not correlate with the quality indicators or the low utilisation rate of community clinics as detailed in other sections of this report.

**Recommendation 24:** Additional engagement with workforce members following transition on the effect of the change should take place to address staff concerns and further communicate outcomes and experiences of the transition.

**Recommendation 25:** In future services changes, more could be done to prepare staff for the changes, particularly in regard to the increase in activity for staff moving to busier units.

### 7.4 Midwifery trainees

In April 2015, Health Education England, North West London (HEE NWL) hosted a student forum, which included representation from midwifery students from the University of West London (UWL). They were keen to feedback about the very positive aspects of moving from Ealing Hospital, despite this being potentially stressful and difficult for them. They welcomed the organised visits to the three other units linked to UWL to help them make an informed choice about their preferences and the maternity units that ultimately received them had been welcoming and supportive, thus making a potentially disruptive event very successful.

This clearly reflected the work of the University, the receiving placement providers and the individual mentors for the students. Informal feedback from the Ealing students was that the Lead Midwife for Education at UWL was particularly pivotal to the seamless transition. She communicated in one-on-one conversations, team meetings, email messages and at conferences to ensure that everyone was well informed about changes as they occurred, minimising apprehension and fear that the moment of uncertainty might have created. She negotiated with the trusts to ensure that the vast majority of students had their first choice hospital allocated. Finally, to contribute to the development of student experience, she encouraged the students to view this challenge as an opportunity to develop flexibility and expand their skills in working in different units, thus expanding skills and learning experience.

Midwifery trainees also participated in the midwifery focus groups run by Membership Engagement Services. There were four trainees who participated in these overall and, when asked specifically how the transition had affected them, their response was more positive than the midwives. They all agreed that post-transition, they were able to experience more births, which all saw as a benefit. Working in a different unit also gave those who had moved from Ealing more confidence in their abilities.

### 7.5 Obstetrics and gynaecology postgraduate medical trainees

Obstetrics and gynaecology postgraduate medical trainees usually rotate to a new trust each year in October as part of their training programme, which enables them to experience different training opportunities. Each of the six trainees working at
Ealing Hospital at the time of the transition was matched to the trust they would rotate to in October, according to their specific training needs. These training placements were spread across NW London.

No obstetrics and gynaecology trainees have resigned following the transition and no new ones have yet been recruited because the recruitment cycle is annual. At present, Health Education England believes there are more obstetrics and gynaecology trainees than the projected number of consultant posts that will be available in the future, and therefore a national review of obstetrics and gynaecology workforce is underway with the recommendations due to be published in the summer 2016.

Health Education England, North West London plans to review trainee placements again in July 2016, one year after the transition. This will include a review of information on trainee preferences for placements and feedback from the General Medical Council National Trainee Survey, which forms part of the quality data, and would be a useful indicator for a future review. A trainee’s perspective on how they will be supported and valued strongly influences their choice of placement. No trainees failed to meet their annual competencies as a direct result of the transition of services from Ealing.

Health Education England, North West London via Imperial Lead Provider sent out an online survey to the 149 obstetrics and gynaecology trainees and training leads in NW London to seek views and feedback on the impact of this transition. The survey was undertaken in November 2015 and focused on the impact of the closure of the maternity unit at Ealing on activity and quality of training and asked individuals to comment on the following areas:

- Has your workload been affected by the closure of the maternity unit at Ealing Hospital? If so, please comment;
- Has the activity in obstetrics increased after the closure of Ealing maternity unit? Please comment;
- Has the activity in gynaecology increased after the closure of Ealing maternity unit? Please comment;
- Has the quality of training changed due to the closure of the maternity unit at Ealing Hospital? Please comment;
- Do you have any further comments about your training post?

Initial findings from the 33 responses received (22%), from trainees of varying grades ranging from ST1 to ST7, would indicate there is a general feeling that the O&G workload across the NW London has increased for trainees as a result of the changes to Ealing maternity. The general increase in workload corresponds with a similar increase to obstetric activity across NW London sites. Feedback on gynaecology activity reported that activity had increased at most sites, with the exception of Northwick Park Hospital and Chelsea and Westminster Hospital where it was felt to be no different. There was a split view regarding the impact of changes on the quality of training; some trainees cited the increased workload as a barrier to accessing appropriate training opportunities whereas other felt the increase volume offered more opportunities. This view was consistent across NW London.
**Recommendation 26:** Health Education England North West London to review trainee placements as planned one year following the transition and factoring in information on trainee preferences for placements as one indicator of training quality.

### 7.6 General Practitioners

GPs are the gateway to referral into maternity services in the majority of cases. To obtain feedback on the transition from GPs, a survey was developed with Ealing GPs to ask for their opinion on the quality of the information they received and impact this has had on referrals of women to the six maternity units in NW London. The full survey is detailed in Appendix 3. The survey was offered to all CCGs for distribution and Ealing, Brent, Hammersmith & Fulham and Hillingdon CCGs, the four areas most affected by the transition, circulated it to member practices in January 2016.

There were 21 survey responses received in total, 12 of which were from Ealing practices, equating to a 15% response rate from their 78 member practices. All GPs who responded believe that women consulting them for referral to maternity services usually need some form of support to make an informed choice about their options. Interestingly, advice from the GP was thought to be more of a key factor in women's choice in Ealing CCG when compared to the other CCGs, potentially reflecting women's greater reliance on this following the major changes in the borough. The other key factors GPs thought influenced women's choice are the unit's reputation for quality of care, recommendations from friends or family, the unit's proximity to home and previous experience of the unit. Proximity of the maternity unit to the GP practice was not thought to be an influencing factor.

With regard to communication about the changes, 57% of GPs (75% in Ealing) felt the information received from their CCG was effective or very effective in helping them to communicate changes, while 29% thought it was neither effective nor ineffective and 14% thought it was ineffective. Patient information leaflets were less helpful to the GPs in communicating changes; less than a third reported these were effective. The most useful elements of the information received were the summary of travel details on the referral letter and the poster detailing the different centres available in Ealing for community care.

In Ealing, some of the GPs reported that some women still thought inpatient maternity care was available at Ealing after the transition, in line with the feedback from London North West Healthcare Trust. The feedback from those who responded from Brent, Hillingdon and Hammersmith and Fulham CCGs has been that the transition has not affected their referral pathways, although there have been some challenges when maternity units were full and did not accept any more referrals. One of the Hillingdon GPs did not appear to be aware of the Maternity Booking Service to support them with referral to other units.

Finally, with regard to community provision, there is almost an even split in opinion across all GPs with 38% rating it good, 33% rating it neither good nor poor and 29% rating it poor. The majority of Ealing GP respondents are also unsure if the redistribution of community boundaries in Ealing has improved continuity of care for women. This reflects the confusion surrounding the shared Ealing catchment area
between LNW and Imperial Healthcare Trust. A previous recommendation in this report has been made to define this catchment area more clearly and thereby improve continuity of care for women living in this area.
Chapter 8: Summary of good practice and recommendations

This review of the first six months following the transition of maternity and neonatal services has highlighted many areas of good practice. Factors key to the success of the transition have been highlighted through the report and are summarised below as key learning for future transitions. In addition, there are several areas identified for further focus to ensure the intended benefits are fully realised. These recommendations should be monitored to ensure they are completed in order to further improve the maternity model of care in NW London.

8.1 Summary of good practice learning to inform future transitions

1. It is important to agree a strong set of clinical quality aims with all stakeholders against which performance can be measured in addition to the more simple transitional process measures.

2. Direct verbal contact with women, rather than relying on written communication, resulted in a smooth transfer and no unexpected births at Ealing following the transition.

3. The transfer process was clinically led and all women were clinically assessed prior to transfer ensuring appropriate care was put in place.

4. Vulnerable women were a clinical priority and received high priority in the acceptance criteria. This has been continued through the Maternity Booking Service so that vulnerable women are always able to access their first unit of choice.

5. A central booking system improves system resilience, minimises disruption for women who are unable to book into their first choice unit and improves access to care for women.

6. It is important to establish a clinical outcomes dashboard prior to the transition and use this to monitor quality performance and guide on-going discussions.

7. The agreement of a consistent model of care across the network with agreed community catchment areas is instrumental in improving continuity and quality of care for women.

8. A cautious activity model, building extra capacity into the system, facilitated women’s choice following the transition and built in resilience. Once the system stabilises this additional capacity can be reviewed.
9. A comprehensive set of information material, developed with lay partners, brought together information on maternity care across NW London for the first time, facilitated women’s choices and was well received.

10. Additional staff retention and development packages helped retain staff through an unsettling time.

11. A coordinated, sector-wide approach to recruitment with agreed principles of not encouraging staff to move between units had significant impact on vacancy levels.

12. This was a clinically-led transition with good engagement from all providers and commissioners, supported by a strong programme management approach. This was key to the success of the transition and the benefits of the strong clinical network continue to be realised beyond transition.

13. Senior grades need more support to settle into new positions, especially if there is a significant change in their role. Senior midwives changed from being largely administrative at Ealing, to more clinical roles at the receiving trusts, which some found challenging.

8.2 Summary of recommendations

1. NW London maternity network to assess current progress against the new national review recommendations and develop an action plan to deliver to them.

2. SaHF and the NW London clinic network should share the MBS model with the wider London network to consider if this approach should be taken across London. This would also assist women from NW London who choose to book outside of the sector.

3. Providers need to work in partnership with commissioners and local authorities to understand the planned provision and role of children centres in the future. Negotiations should be held with Chiswick children’s centres to agree access for local women.

4. Commissioners and providers need to work together to agree commissioning arrangements for shared antenatal care. In future transitions, contracting issues that affect transition should be managed within the transition framework.

5. Review the utilisation of clinics as Ealing Hospital and refine the clinic capacity and demand.

6. Providers should work with women in the area to highlight that they can access high quality antenatal care by the same team who will deliver their
baby, without the need to travel to the centre where they have chosen to give birth.

7. Within the next six months the maternal diabetic pathway needs to be reviewed across the sector to ensure provision of specialist services to meet clinical need.

8. In line with national and London-wide guidance, labour and birth in alongside midwifery led units should be actively promoted for low risk mothers as they are associated with a lower risk of unnecessary interventions and increased satisfaction.

9. West Middlesex Hospital and Hillingdon Hospital should continue to actively recruit midwives to achieve the 1:30 target set out in the London Quality Standards and agree a plan to achieve this ratio with their respective commissioners.

10. Undertake immediate review of data collection processes with respect to 1:1 midwifery care in labour to ensure consistency of methodology across trusts. Imperial Healthcare Trust need to revalidate their 1:1 care in labour data. Compliance with this should be monitored through their Care Quality Group.

11. Each trust should work with commissioners to finalise plans to further improve clinical cover on labour wards in 2016/17, taking in to account any new guidance issued in this area. St Mary’s Hospital needs to increase the consultant presence on the labour ward as soon as possible - this needs to be monitored by their Care Quality Group.

12. An in-depth analysis of the quality data should be conducted when one year of data is available, to compare to pre-transition data and benchmark against other maternity units in London for measures such as caesarean section rates, assisted deliveries and complications, babies born before arrival, haemorrhage, normal birth, booking by thirteen weeks.

13. Continue to review and adjust the community areas to ensure they are aligned with women’s choice so that continuity of antenatal and postnatal care can be provided.

14. Review the booking data in the shared area to redefine the trust boundaries so there are no shared areas.

15. Continue to monitor compliance with providing continuity of through antenatal and postnatal care.

16. Confirm and fully commission an agreed model of transitional care across NW London with an agreed tariff. The impact of this on neonatal admissions and length of stay should be actively monitored.
17. Review the impact of the perinatal mental health pilot and spread learning through NW London.

18. An urgent review of capacity and catchment areas at Northwick Park Hospital is required to address the forecasted rise in activity beyond the expectations of commissioners and the unit’s capacity.

19. Continue to monitor activity at the other maternity units, particularly as the changes to the trust catchment areas embed, to ensure there are no issues with capacity.

20. A neonatal nurse focus group should be organised to obtain feedback from this staff group about their experience of the transition.

21. Ensure further communications are provided to women in relation to their choice of antenatal and postnatal care, especially within the borough of Ealing.

22. The uncertainty about the decision to implement the maternity and neonatal transition had a negative impact on staff experience and engagement in the changes. Decisions for future changes need to be made further in advance of implementation, to prepare staff.

23. Trusts need to ensure an effective route in communicating with their staff. This needs to be coordinated by an accountable individual to prevent mixed messages, rumours, and disengagement.

24. Additional engagement with workforce members following transition on the effect of the change should take place to address staff concerns and further communicate outcomes and experiences of the transition.

25. In future services changes, more could be done to prepare staff for the changes, particularly in regard to the increase in activity for staff moving to busier units.

26. Health Education England NW London to review trainee placements as planned one year following the transition and factoring in information on trainee preferences for placements as one indicator of training quality.
Conclusion

NW London has managed a complex service change safely and with clear benefits to patients, mothers and their babies. New community services have been developed, facilities at the receiving hospitals invested in, a significant number of new midwifery staff appointed and the maternity and neonatal units closed safely and to the planned date. Furthermore the majority of women who had their care transferred felt supported and well communicated with. Whilst it has been a major change for staff who worked at Ealing hospital, they are beginning to feel more settled in their units and through the strong head of midwifery network that has been formed; they will continue to be actively supported.

The benefits case for the new model of care set out clear objectives and expected outcomes that the transition of services should achieve. This review has considered the progress towards the achievement of these benefits; in so doing much good practice has been highlighted as well as several recommendations for the further development of the service.

After a large service change, such as this, the system will take time to normalise. It is therefore recommended that the key quality indicators continue to be actively monitored and that a further in-depth review is undertaken in 2017, this will also provide an opportunity to assess progress against the National Maternity Review.
Appendix 1: Maternity care for Ealing residents' information poster
# Appendix 2: Quality and system monitoring dashboard

## Metrics - Maternity (Monthly)

<table>
<thead>
<tr>
<th>Demand</th>
<th>Capacity</th>
<th>Quality</th>
<th>Resilience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (Births)</td>
<td>Delivers (Births) by women from Ealing postcodes</td>
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<td>Deliveries (Births) by women from Ealing postcodes</td>
</tr>
<tr>
<td>Births in MLU</td>
<td>Births at Home</td>
<td>Births at Labour Ward</td>
<td>Bookings</td>
</tr>
<tr>
<td>Bookings</td>
<td>Bookings by women from Ealing postcodes</td>
<td>NICU cot days</td>
<td>Maternity Serious Untoward Incidents</td>
</tr>
<tr>
<td>Maternal support vacancy rate</td>
<td>Neonatal nurses vacancy rate</td>
<td>Consultant vacancy rate</td>
<td>Maternity to birth ratio</td>
</tr>
<tr>
<td>Consultant (Anaesthetic) vacancy rate</td>
<td>Sonographer vacancy rate</td>
<td>Midwifery to birth ratio</td>
<td>Midwifery to birth ratio</td>
</tr>
<tr>
<td>NICU cot days</td>
<td>Consultant cover on labour wards (hours)</td>
<td>1:1 midwifery labour care</td>
<td>1:1 midwifery labour care</td>
</tr>
<tr>
<td>Emergency C-Sections</td>
<td>Elective C-Sections</td>
<td>12+6 weeks booking rate (exc. late referrals; i.e. after 10+6 weeks)</td>
<td>12+6 weeks booking rate (exc. late referrals; i.e. after 10+6 weeks)</td>
</tr>
<tr>
<td>Average Friends and Family Test score</td>
<td>Number of complaints</td>
<td>Number Born Before Arrival</td>
<td>Number Born Before Arrival</td>
</tr>
<tr>
<td>Unbooked deliveries</td>
<td>Attrition Rate (Bookings to Deliveries)</td>
<td>Breastfeeding initiation rate</td>
<td>Breastfeeding initiation rate</td>
</tr>
<tr>
<td>% of women with Post Partum Haemorrhage (&gt; 1,500mls)</td>
<td>% of instrumental deliveries</td>
<td>% of Puerperal Sepsis</td>
<td>% of Puerperal Sepsis</td>
</tr>
<tr>
<td>Number of Temporary Closures</td>
<td>Women getting first choice unit</td>
<td>Number of first choice bookings turned away</td>
<td>Number of first choice bookings turned away</td>
</tr>
</tbody>
</table>

## Metrics - Maternity (Weekly)

<table>
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<th>Demand</th>
<th>Capacity</th>
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<th>Resilience</th>
</tr>
</thead>
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<tr>
<td>NICU cot days</td>
<td>Maternity Serious Untoward Incidents</td>
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</tbody>
</table>

## Metrics - Neo Natal (Monthly)

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<tr>
<th>Demand</th>
<th>Capacity</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Utero Transfer within NWL</td>
<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
</tr>
<tr>
<td>In Utero Transfer to another Network</td>
<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
</tr>
<tr>
<td>Postnatal Transfer within NWL (Medical &amp; Surgical)</td>
<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
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<tbody>
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<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
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<tr>
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<td>Postnatal Transfer to another Network (Medical &amp; Surgical)</td>
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</tbody>
</table>
Appendix 3: GP survey

1. Practice Name
2. Practice Code
3. CCG
   - Brent
   - Central London
   - Ealing
   - Hammersmith & Fulham
   - Harrow
   - Hillingdon
   - Hounslow
   - West London
4. How effective was the information from the CCGs in updating you on the transition of maternity and neonatal inpatient services from Ealing Hospital and what this meant for you and your patients?
   - Very ineffective
   - Ineffective
   - Neither effective nor ineffective
   - Effective
   - Very effective
5. Free text box for further information if applicable (4000 characters)
6. How effective were the patient information materials (e.g. booklets and posters) in helping you communicate the changes to the women affected and the associated travel arrangements?
   - Very ineffective
   - Ineffective
   - Neither effective nor ineffective
   - Effective
   - Very effective
   - I have not seen this information
7. Free text box for further information if applicable (4000 characters)
8. How much support do you think women need from their GP in choosing a maternity unit?
   - No support
   - Minimum support
   - Moderate support
9. What factor(s) do you think are most important in helping women make a choice about which maternity unit they would like to be referred to? (Multiple options may be selected)
   - Proximity of the maternity unit to home
   - Proximity of the maternity unit to the GP practice
   - Availability of community services close to home
   - Previous experience of the maternity unit
   - Recommendations from friends or family
   - Maternity unit’s reputation for quality of care
   - Advice from GP
   - Other

10. If other, please specify

11. Have you had any problems referring to any of the maternity units following the transition?
   - Yes
   - No

12. If yes, which maternity unit(s) have you had problems referring to? (Multiple options may be selected)
   - Not applicable
   - Chelsea and Westminster Hospital
   - Hillingdon Hospital
   - Northwick Park Hospital
   - Queen Charlotte’s and Chelsea Hospital
   - St Mary’s Hospital
   - West Middlesex University Hospital

13. If yes, why was this a problem? (Multiple options may be selected)
   - Not applicable
   - Administrative or clerical reason
   - Maternity unit capacity issue – patient lives within catchment area
   - Maternity unit capacity issue – patient lives outside of the catchment area
   - Other

14. If other, please specify

15. How would you rate access for your patients to community maternity clinics since the transition of maternity services?
   - Very poor
   - Poor
- Neither poor nor good
- Good
- Very good

16. Question for Ealing GPs only - Do you think continuity of care has improved since all the Maternity Units now provide antenatal and postnatal community care in Ealing?
- Yes
- No
- Not sure

17. Is there any other information about maternity care in NW London that would be helpful for you, your practice and your patients? (Free text box for further information if applicable)
Appendix 4: Women’s experience survey

Feedback on Your Maternity Care

The survey should take no more than 15 minutes of your time and will remain open until 15th January 2016. The purpose of this survey is to get feedback on your experience of your maternity care being moved from Ealing Hospital to another maternity unit in North West London. All responses are in total confidence and comply with Market Research Society Code of Conduct. You will not be able to be identified through your answers.

Questions:

1. Which hospital was your maternity care moved to? [Please tick only one]
   - Chelsea and Westminster Hospital
   - Hillingdon Hospital
   - Northwick Park Hospital
   - Queen Charlotte’s and Chelsea Hospital
   - St Mary’s Hospital
   - West Middlesex University Hospital
   - Don’t know/Not Sure

2. Were you given any information about other hospitals and travel?
   - Yes
   - No [skip to question 5]
   - Don’t know/Not Sure [skip to question 5]

3. If yes at question 2, what materials or information did you receive? [Please tick as many as apply]
   - Letter
   - Giving birth booklet [see Image 1]
   - Giving birth Easy Read booklet
   - [see Image 2]
   - Bus map [see Image 3]
   - Other (please state)
   - Don’t know/Not sure

4. If yes at question 2, how did you receive this information? [Please tick as many as apply]
   - Midwife
5. Please state to what extent you agree or disagree with the following statement: ‘Overall, I feel I had enough information about other hospitals where I could give birth.’ [Please tick only one]
   - Disagree strongly
   - Disagree
   - Neither agree nor disagree
   - Agree
   - Agree strongly
   - Don’t know/Not sure

6. Please state to what extent you agree or disagree with the following statement: ‘Overall, I feel I had enough travel information.’ [Please tick only one]
   - Disagree strongly
   - Disagree
   - Neither agree nor disagree
   - Agree
   - Agree strongly
   - Don’t know/Not sure

7. If you did not feel as though you had enough information on either hospitals or travel, please tell us what additional information would have been useful? [FREE TEXT BOX FOR RESPONSE]

8. Did your midwife ask you about your travel plans to the hospital where you were moved?
   - Yes
   - No
   - Don’t know/Not sure

9. Where did you receive your antenatal (before birth) and postnatal (after birth) care? [Please tick as many as apply]
   - Hospital
10. Please state the extent to which you agree or disagree with the following statement: ‘Overall, I have felt less able to get to my antenatal (before birth) and postnatal (after birth) appointments on time after I moved hospitals’ [Please tick only one]
   - Disagree strongly
   - Disagree
   - Neither agree nor disagree
   - Agree
   - Agree strongly
   - Don’t know/Not sure

11. Please state the extent to which you agree or disagree with the following statement: ‘Overall, I have felt less able to get to my hospital-based appointments, including scans, on time after I moved hospitals’ [Please tick only one]
   - Disagree strongly
   - Disagree
   - Neither agree nor disagree
   - Agree
   - Agree strongly
   - Don’t know/Not sure

12. Did you have any other travel difficulties after the hospital providing your maternity care changed?
   - Yes
   - No [Skip to question 14]
   - Don’t know/Not sure [Skip to question 14]

13. If yes, why?
    [FREE TEXT BOX FOR RESPONSE]

14. Please state the extent to which you agree with the following statement: ‘Overall, I felt supported when my maternity care was moved from Ealing Hospital’ [Please tick only one]
   - Disagree strongly
   - Disagree
- Neither agree nor disagree
- Agree
- Agree strongly
- Don’t know/Not sure

15. Why do you say that?
[FREE TEXT BOX FOR RESPONSE]

16. Please state the extent to which you agree with the following statement:
- ‘Overall, I was happy with the maternity care I received after I moved hospitals’
  [Please tick only one]
- Disagree strongly
- Disagree
- Neither agree nor disagree
- Agree
- Agree strongly
- Don’t know/Not sure

17. Which parts of your care were you most happy about?
[FREE TEXT BOX FOR RESPONSE]

18. Are there any parts of your care that could have been improved?
[FREE TEXT BOX FOR RESPONSE]

**Your Details:**
If you would like to receive a £10 high street voucher as thanks for taking part in the survey, you can give your contact details so we can post this out to you. You have our guarantee that these details will in no way be used to identify your responses and you do not need to give you details if you don’t want to.

Name:

Postal address:
Contact us:

Email: Healthiernwl@nw.london.nhs.uk

Online: www.healthiernorthwestlondon.nhs.uk

Twitter: @HealthierNWL

Freepost: FREEPOST, Healthier North West London

Freephone: 0800 1777 990